# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's N	Name (First, Middla, Las.	1-29-99 WR.		Certifi	icale 0	f Death	2. Data of D	Reg. No.	3.	Time of Death	
ian cal ner		TA H		AN	E		4b_Çity, Town,	or Location of Dear	mber/	2,1998 y of Death	16:3	
iei	The.	Johns	Hookir	25	Hosp	ital	Batt	more		TIMORE		
		2-4629		(In yrs. la		Under 1 Yee onths Day		Hrs. 8. Data of Bi Min. (Month, D FEB 17	rth ay, Year) 7, 1917	9. Birthplace Country) DELAW	(Stata or Fore	
	Usual Rasidano 10a. Stata	10b. County		10c. City,	Town or Location	on				10d. lr	nside City Lim	
al Director	DE	KENT			MILFOR	RD			10			
	10e. Street and Number 10f. Zip Code 19963								10g. Citizen of	What Country? USA		
Dy rullela		Married 2 Married	1 Vac 2 No		es Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puarto Rican, etc.)  Yas 2 No Specify:			No- 14. Race - American Indian, Black, Whita, atc.  Specify: WHITE				
-	(5	15. Decedent's Edu	cation 16a. D		16a. Decedent's	s Usuel Occ	upation e during most of	working	16b. Kind of Business/Industry			
Completed		Secondary (0-12)	Collega (1-4or 5+)		lifa. DO N	VOT use retir	red)		PHYSTC	IANS OFFICE		
	17. Fathar's Nar	ma (First, Middle, Last) HENDRICKS				REGISTERED NURSE  18. Mother's Nem  GRACE					200	
•		s Name/Reletionship (T)	ype, Print)		The second secon			SANTA ROS		er, City or Town, Stata, Zip Code) A. CA 95404		
		Disposition  2 Cremetion 3 Fon 5 Other (Specify)		cer	ce of Disposition metary, cremato	n (Name of ry or other p	lace)	Date 12-16	20c. Location - City or Town, Stata MILFORD, DE			
		Funaral Service Licens		,	22. Ne BERF	ma and Add	rass of Facility			- 44		
	Immediete Cau disaasa or cond	se (Finel dition	MULT	196	086		ying, such as car	•	arrest,	Ons	val Between et and Death	
dicai		dition th) t conditions, o immadiata inderlying o or Injury ants	c	Dua to (or a		ce of):	FAILUR	ε.	,	Inter Ons	DAy 3	
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Be Completed by Physician/Medical	Sequentially list if any, teeding to cause. Enter U cause (Disease that initiated evrasulting in deal	t conditions, o immediate inderlying or injury ants th) Last	b. CONONAR  c  d  Intributing to death but	Dua to (or a	as a consequence	ce of):  ce of):  ce of):  dying causa g	FAILUR PENARH  piven in Part I.  26. Place of	23b. Did 1 24a. Wa	tobacco use colyse 2 No	ontributs to the  3 Probably  24b. Were as available complet of death  1 Yes	cause of dea	
to be completed by Physician/Medical	Sequentially list if any, leeding to cause. Entar U cause, Close as that initiated ever resulting in deal.  Part II. Other sky  25. Was case re examiner?  1 Yes 2  27. Manner of D  1 Anaturel	t conditions, o immadiata inderlying ants th) Last  gnificant conditions conditions conditions to medical  aferred to medical  No  eath  5 □ Pending	b. Cokon AR	Dua to (or a	as a consequence as a c	ce of):  ce of):  iving causa (	FAILUR  PENARH  given in Part I.  26. Place of other: 4    Nursin	23b. Did 1 24a. Wa perl	tobacco use colyse 2 No	ontributs to the available complet of death	cause of dea	
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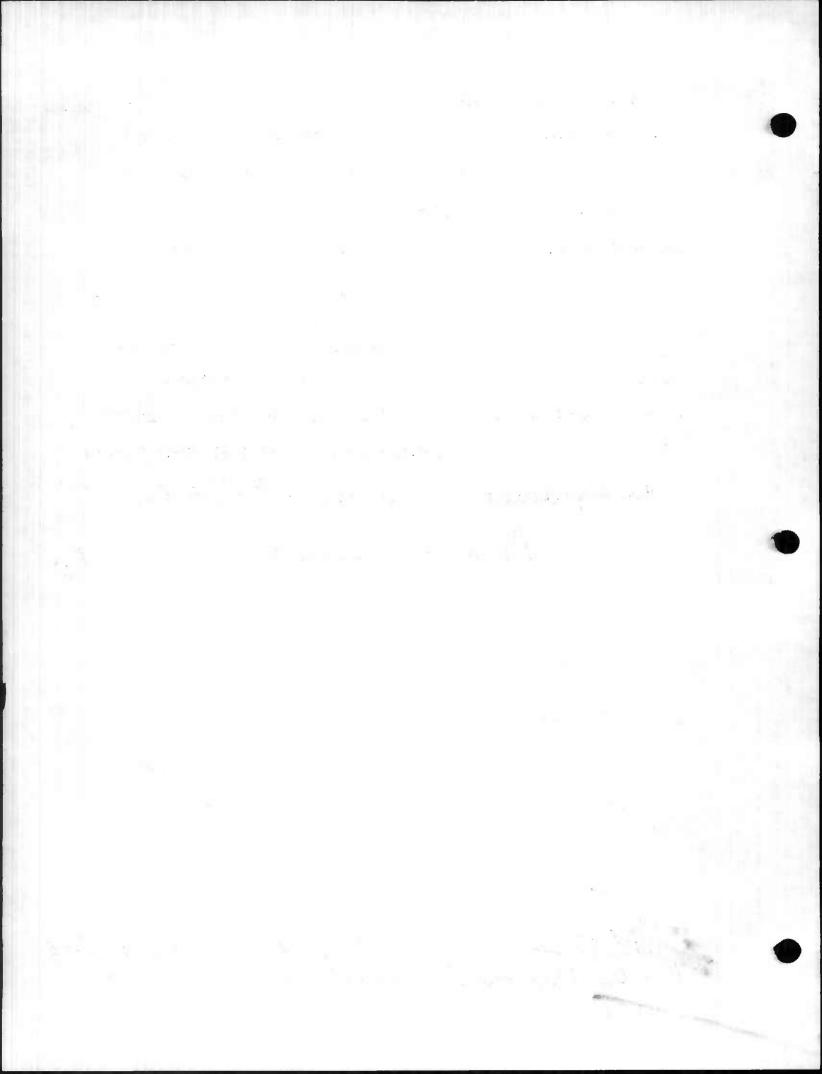
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State of Maryland / Department of Health and Mental Hygiene 98 4 1 1 3

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Funeral Director		5. Social Security N 213-34-2	233	Sex 1□ M 2【XF	7. Age (In yrs. 96	lest birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Date of E (Month, I Mar 31	Birth Dey, Year 190	2	Birthpi Count Oh10	iece (Stete or try)	Foreign
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tar dea Items	by Funeral Director	11. Marital Stetus 1 □ Never Marr 3 ☑ Widowed	led 2 Married	12. Wes Dec Armed Fo 1  Yes If Yes, Gi Yeer or D	2 No ve No	It Yes, specif		city Cut	of Hispenic Origin? (Specify Yes or Cuben, Mexican, Puerto Rican, etc.)  No Specify:			No- 14. Rece - Ame Bleck, Whit			etc.	
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Balt permit. Depertr Imports any Inju		21. Signeture of Fu	Haight		t				ess of Fecili	На	ight F			me & Chapel		
Physician /Medicai Examiner	ler	23a. Part1. Enter to shock, or hee Immediate Cause ( disease or condition resulting In daeth)	(Finel	e. One couse on a	STASTA	r as e conseq	Tora		Срис						Approximate Interval Batw Onset and D	reen
BOX 68/60, eath certificate be executed attending physician end for use es the burial-transit	Completed by Physician/Medical Examiner	Sequentially list co if eny, leading to in Cause (Disease or that initiated events resulting in death) i	injury	c		r es e conseq r as a conseq										
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aw requir	pieted by										24e. We	s en auto formed?	psy	eve	ra autopsy fir illeble prior to apletion of ca leath?	
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To the Hospital within 24 hours To the Funeral completely filled	edicai	29a. Certifier (Check only one)	2 Medical Exa	miner: On tha bi	best of my know asis of axaminat ner steted.	wiedge, deeth ion end/or inv	occurred e estigetion,	In my	me, dete en opinion, dea	d pleca, th occur	and due to the red at tha time	e cause(s e, data and	) end menn d placa, end	er ea sto d due to	ated. the cause(s)	
To the To the comp	Me	29b. Signature and	title of certifier	>			29c	Licen	se number	2_		29d. Da	ite signed (	Month, E	Dey, Year)	8
		30 Nama and eddy	ess of person who	complated caus  D 34	se of death (Hern	23e) (Type,	Print)	7 1	in la	3	62	Me	21	· 4:	3	
Sta Regista		31. Dete filed (Mont	th, Dey, Year) 1 8 1998		egistrer's Signa	G.	doar	K	,							



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizabeth I. Thompson December 24, 1998 /Medical 1530 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sunrise Care and Rehabilitation Elkton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Montha Hours 1 M 2 F Yrs. 171-10-2849 81 1917 Director Pennsylvania Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 1 Yes 2 No Pennsylvania Chester Oxford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 8 234 Ox Haven Apartments 19363 United States Funeral Hema 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married natural, or Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 10 Food Handler Hospital 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Heelth and Mental Hy Important: If them 27 le marked ofth enty Injury or other treumatic event page. Pierce Ingram Mary Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pennsylvania 19a. Informant's Name/Relationship (Type, Print) Ethel Kay Yates/ Daughter 103 North Deer Run Drive, Lincoln University, 19352 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place) December 28, West Chester, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris and Company 1998 Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 chee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert feiture. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** /Medical immediate Cause (Finel 423 diseese or condition resulting in death) Examiner Physician/Medical Examiner myasaular physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 68760 Due to (or as a consequence of) . Box P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Tyes 2 No Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vitai Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how triury occurred 28b. Time of Division 1 Natural 5 Pending investigation t ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted. edical 29e. Certifier ŝ 29c, License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) Jachders Mr

State Registrar 31. Dete filed (Month, Day, Year) DEC 2 8 1998

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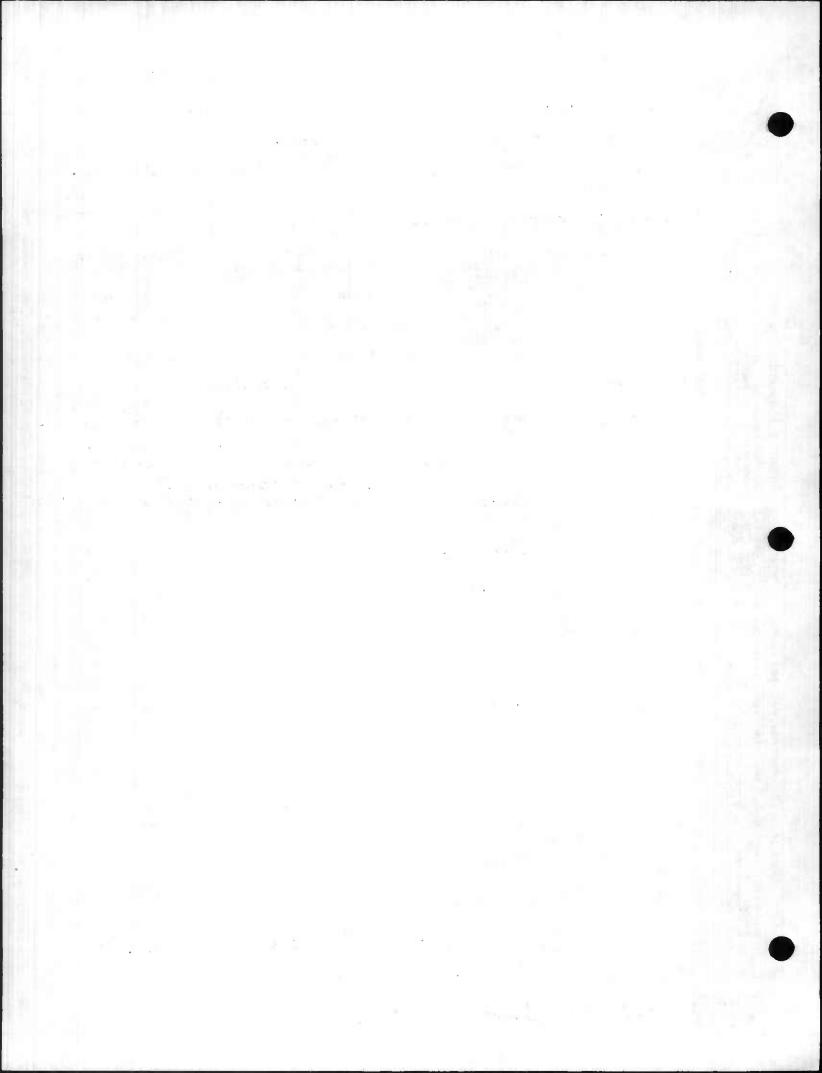
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Elk 60, MD 21924

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Self DEV, 1/8 North St Stute

32. Registrer's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 23, Freddie L. Williams December 1998 3:11 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harkord 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (Stata or Foraign Country) Ohio 5. Social Security Number Hours 10 M 20 F Yrs. July 9, 291-40-3221 54 1944 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Maryland Cecil Conowingo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 80 W. Red Hill Rd. 21918 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, atc. Armed Porces: 1 1 Yes 2 No If Yes, Give Year or Dates: 1968-69 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Shop Steward Carpentry 17. Fsther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Idalyn O. Williams/Wife 80 West Red Hill Rd., Conowingo, MD 21918 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 □Other (Specify) State Line Baptist Cem. 12-28-98 Rising Sun. MD 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 1111 S. Queen St., Rising Sun, MD 21911 21. Signature of Funeral Service Licensee Tark Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction myocardial Arthro schuetic Cardisvosscular docume 1 ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): to bacco abral 4 ears Dua to (or as a consequence of): dealetts dependent Insulin 410-5 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco ues contribute to the causs of death? 1XYss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 25. Was case referred to medical examine? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

1 Yes 2 No

D31295

Ab-uden

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Plaza

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

md

29d. Date signed (Month, Day, Year)

Examiner

**Physician** 

/Medical

Examiner

ā

Funeral

P

Completed

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**Funeral** 

Director

Ahow

il Hygiena. other than "natural", or flema 23a or 28a-f ahov vant, the Medical Examiner man be notified at

Pages 1 and 2 should be filed within 72 hours after and of Meltih and Mental Hygiens.
Int: If hem 27 is marked other than "natural; or he ury or other traumate avent, my secure.

permit. Page Department of Important: If any injury or

Physician

/Medical

altimore, Maryland 21215-0020

Examiner Physician/Medical Be Completed by Certification: To this s death. ne Hospital or Attandi n 24 hours after death. ne Funeral Director: A pletaly filled in by the f

To the Hosp within 24 ho To the Fune completely f

Division of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Medical

Wendy Kloesz, m.D. 31. Date Fled (Month, Day, Year) DEC 2 8 1998

29b. Signature and title of certifier

2 ☐ Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

5 Pending

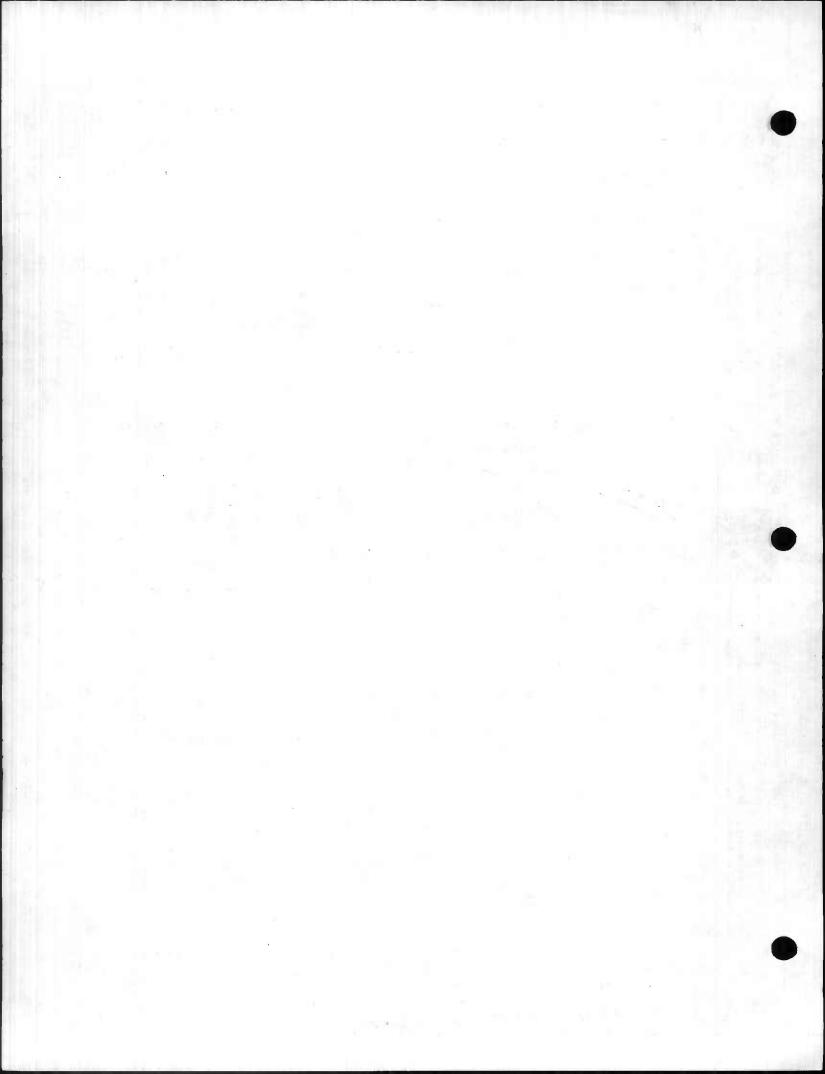
investigation

6 Could not be

Ko Aberdeen

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Neme (First Middle Last) 3. Time of Death 2. Date of Deeth Year Month Dey MARGARET GERTRUDE WILHELM DEC. 16, 7:25 PM 1998 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth UNION BRIDGE 835 RAMPART WAY CARROLL If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) 8. Dete of Birth (Month, Dev. Year) Months Deys Hours 1 □ M 2 1 F Yrs. 12/24/1916 213-09-5420 81 MARYLAND Usuel Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits CARROLL UNION BRIDGE 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 835 RAMPART WAY 21791 USA. 14. Race - American Indian, 12. Wea Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2X No if Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 □ Divorced 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKING 6 18 Mother's Name (First Middle Maiden Sumame) 17. Fether's Neme (First, Middle, Last) **JAMES** ABBOTT GARAFIELA HARE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 835 RAMPART WAY, UNION BRIDGE, MD, 21791 PATRICIA DERR - DAUGHTER 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify) WESTMINSTER CEM. 12/19/98 WESTMINSTER, MD. 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. I ignature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the dise se, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. Unit only one cause on each line. Approximete Intervet Between Onaet end Deeth Immediate Ceuse (Finet disease or condition resulting in deeth) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE! Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence ot): Due to (or es e consequenca ot): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown COPD 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 HO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner** 

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

completely

To the within 2

Department of Important: If any injury or

**Physician** 

/Medical

Examiner

10a Stete

MD.

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Funeral

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**Funeral** 

**Director** 

ahow

7 is marked other than "natural", or flems 23s or 28s-f show traumatic evant, the Medical Examiner must be notified at

nit. Pages 1 end 2 should be filed within 72 hours after cartment of Health and Mentel Hygiene.
ortant: if item 27 is marked other than "natural", or iter
injury or other traumatic event, the Medical Examination

Baltimore,

the Maryland

with

death

physician and the burial-trans 88 USB signed by t certificate

funeral

Box 68760 certificate be P.0. Division of Vital Records, Hospital or Attending Physician:
24 hours after deeth.
 Funeral Director: After this certification.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 1 Netural 5 Pending 1 Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 🛵 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier

29c. Licanse number 14317

29d. Dete signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

ONE KINGS DR. P.O. BOX 452 LINTHICUM, M.D WILLIAM R

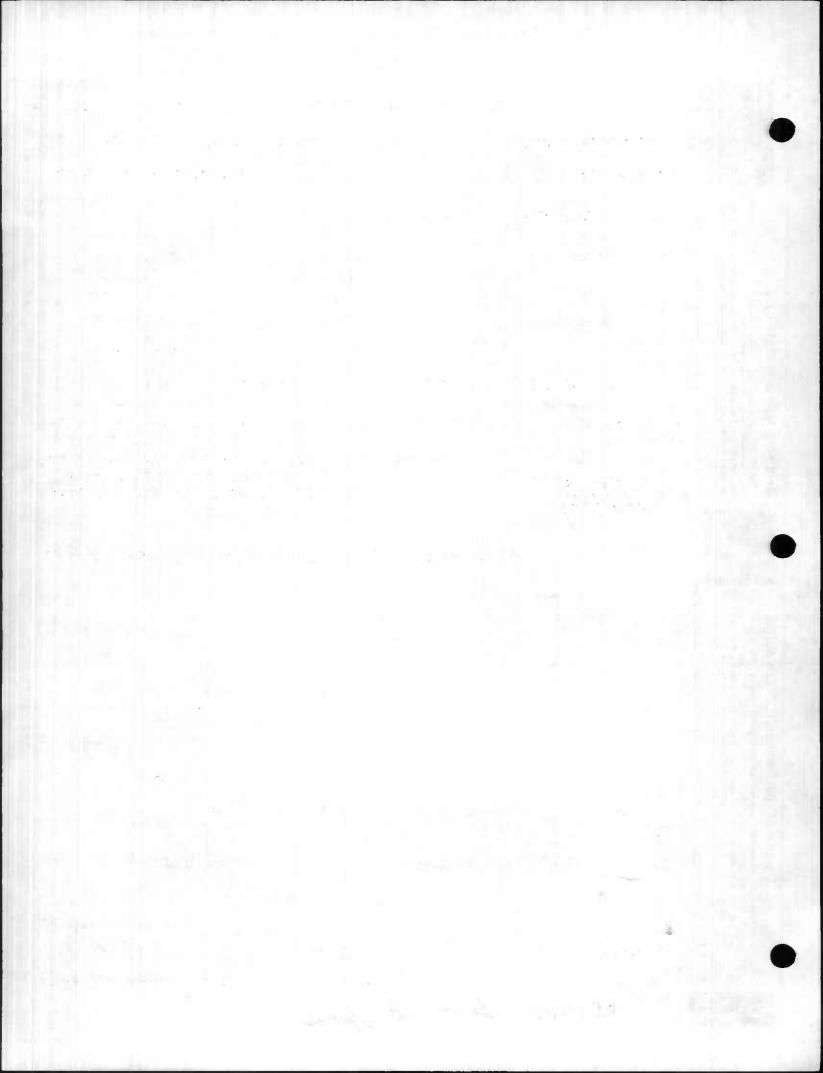
TANEYTOWN MD 21787

State Registrar

DEC 1 8 1998 31. Dete tiled (Month,

32. Registrer's Signature

doorth



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** /Medical 4c. County of Death 4e Fecility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 7. Age (In yrs. lest birthday) If Undar 1 Yaar 6. Sex 8. Data of Birth (Month, Dey, Year) 9. Birthpiece (Stete or Foreign **Funeral** Days Months Hours 10 M 20 F Director with the Maryland 10a. Steta 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Modical Examinar must be notined at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? deeth 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca -Amarican Indian, 11. Marital Status 12. Was Decedant Evar in U.S. Armed Forcas?

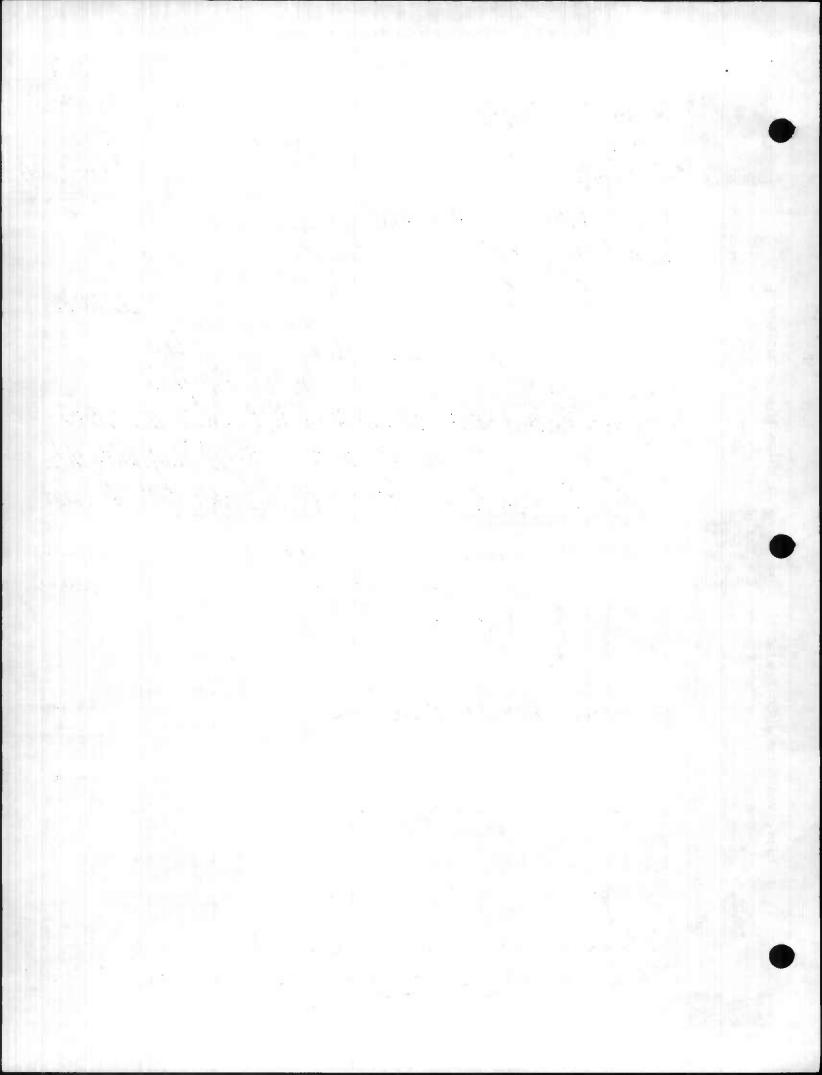
1 (1) Yas 2 | No if Yes, Giva Year or Detes: Black, White, atc permit. Pages 1 and 2 should be filed within 72 hours after of Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item 20 Married 1 Never Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

LAW CLARK Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantery/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) Mothar's Neme (First, Middle, Meiden Sumeme) DWI any injury or other 20a. Method of Disposition 1 Buriel 2 Cremetion 3 □Removel trom Stete 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licanse se, or complications that caused the deeth. Do not enter the mode of dying so. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in deeth) /Medical ARRYTHMIA CARMAC MINUTES Examiner Due to (or es a consequenca of): Examiner CARDIOMYOPATH Sequantielly list conditions, if eny, leeding to immadiate causa. Enter Undarlying Cause (Diseese or injury that initiated evants resulting in death) Last physician end s the buriel-tran Due to (or es e consequence of): YEARS Division of Vitai Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence ot): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the e 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 2 Unknown RENAZ FAILURE 24b. Wara autopsy findings available prior to complation of cause ot deeth? 24a. Was an autopsy performed? Completed hes 1 Yas 2 No 1 Yas 2 No or Attending Physician: Be 25. Wes case reterred to madical exeminer? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA After this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1. Natural within 24 hours after deeth. To the Funeral Director: Al 2 No 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledga, daeth occurred et the time, dete and place, and due to the causa(s) and mannar as stated.

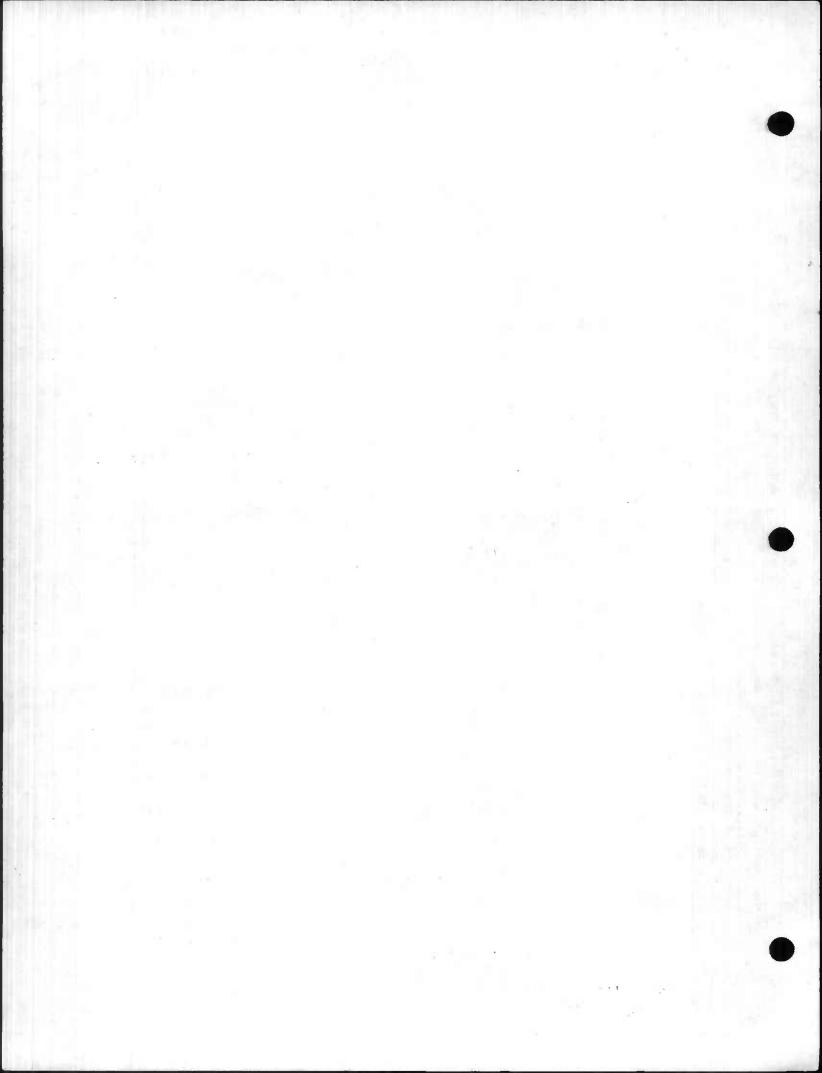
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end menner stated. Medical 29a. Certifier To the 29b. Signeture and titla of certifiar 29c. Licensa number 29d. Dete signed (Month, Dey, Year) 016349 1.6.99 30. Neme end addrass ot person who completed cause ot deeth (Item 23a) (Type, Print) 827 LINDEN AVE BACTIMORE MY 21201 CEDRIC W. BRYAN IND

32. Ragistrar's Signature

State Registrar 31. Date filed (Month, Day, Year)



State Registrar



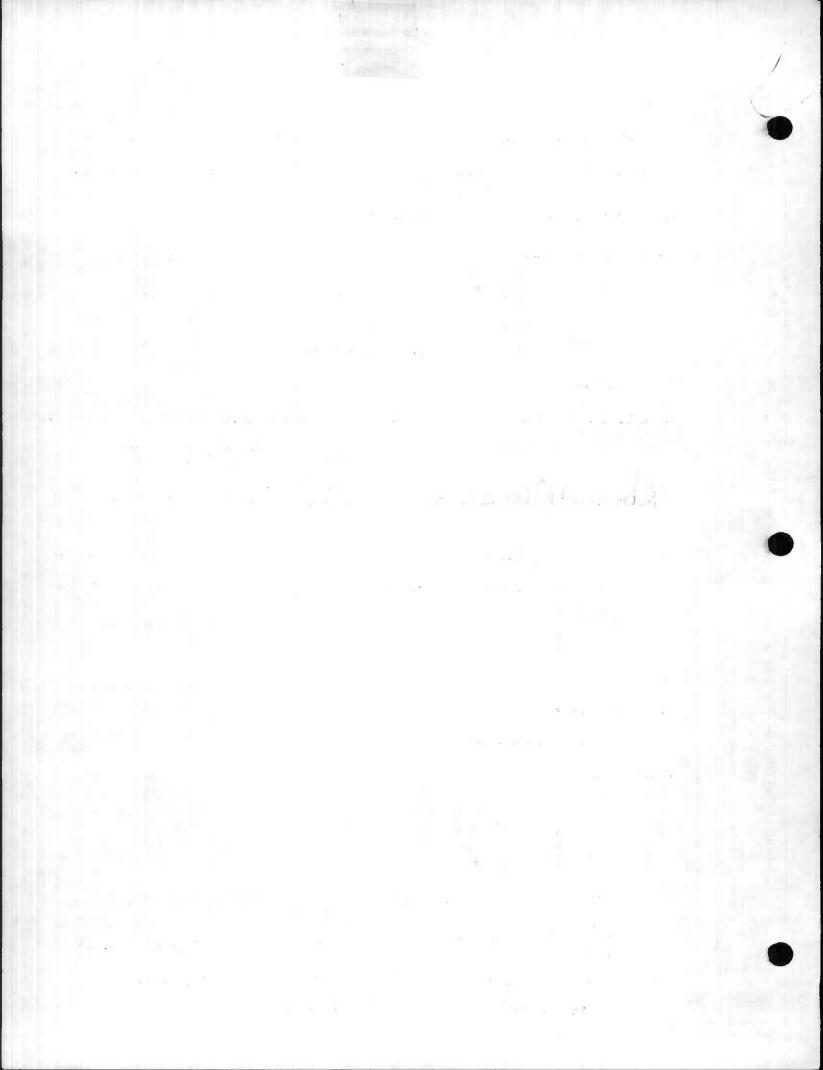
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Daeth 3. Time of Death 1. Decedent's Neme (First, Middla, Last) Month **Physician** 29, 1998 Julia Emma Thompson Gilkes December 3:55 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Doctors Community Hospital Prince George's Lanham if Under 1 Yaer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) August 2, 1 9. Birthplece (State or Foreign Country) New York 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F Months Deys Hours Min Yrs. Not Available 93 1905 New Director Usuel Residence of Decadent Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland user of Heelih and Mental Hygiene. In: If item 72 is merked other than "naturel", or items 23a or 28a-6 show my or other treumatic event, the Margal Exemper wait be notified as my or other treumatic event, the Margal Exemper. 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Prince George's Mitchellville Directo 10g. Citizen of Whet Country? United States 10e. Street end Number 10f. Zip Code 10450 Lottsford Road 20721 of America Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ঐ No If Yes, Give Yeer or Dates: Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Naver Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade com 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) completed) Elementery/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 5+ 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Nema (First, Middle, Last) Percy Thompson Amy Ellis 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) Edith T. Scott / Niece 11150 Homewood Road, Ellicott City, Maryland 21042 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State New Rochelle Important: If it, any injury 1 Buriel 2 Cremetion 3 Removel from State January Beechwoods Cemetery 6, 1999 4 ☐ Donetion 5 ☐ Other (Specify) New York 22. Name end Address of Facility
McCallihan Funeral Home 21. Signature of Funerel Servica Licensee Causer 30 Winthrop Avenue, New Rochelle, New York 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter tha mode of dying, such es cardlec or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) (Verdiga) e. Sepsis Weeks Examiner Due to (or es e consequence of) Examiner Acute Renal Failure Weeks physician end the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): ettending pl signed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atherosclerosis p 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed Multiple Infected Decubitus Ulcer completion of cause of death? certificate hes t Hypotension 1 Yes 2 XNo Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Netural Injury 1 ☐ Yes 2 ☐ No 2 Accident 124 hours efter des Ne Funerel Director pletely filled in by th 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil edical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number akern andly. D 20108 December 30, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 14300 Gallant Fox Lane, Suite 222, Bowie, Maryland Rakesh Arora, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 JAN Registrar

Officers in Bury lysis

DOMA



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 1 per M.D G-767 1/8/99 reb 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death TYREE DEON GREEN DECEMBER 26,1998 breen Baby Boy- Regina 01:54 AM 4a Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY
If Under 24 Hrs. 8. Dete of THE JOHNS HOPKINS HOSPITAL If Under 1 Year 8. Dete of Birth (Month, Day, Year) 12-26-98 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Deys Hours Months M 2DF Yrs. MD Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits XXYes 2 No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 2443 E. Hoffman Street 21213 USA 12. Was Decedant Evar in U.S. Armed Forces? 14. Race - Amarican Indian, 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) Black, Whita, atc. XNever Married 2□ Merried 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Yaar or Datas: 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilega (1-4or 5+) Child Child Infant 17. Father's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Malden Sumame) Unknown Regina Α. 21213 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 2443 E. Hoffman Street Baltimore MD of Disposition (Name of Date 20c. Location - City or fown, Stete Regina A. Green 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 Buriei 2 ☐ Cremetion 3 ☐ Removel from Steta □ Donetion 5 Other (Specify) Voshell Mem. Gardens 01-08-99 Dundalk, MD 21. Sign of Funeral Service Licenses 22. Neme end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Pert1. Enter the disease, or com that ons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Causa (Finei myocardial dystunction 22 hours disaasa or condition resulting in death) unknown hypoxic - ischemic insult Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseasa or injury that initiated evants resulting in death) Last Due to (or as e consequence of): Due to (or as e consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown hypoxic-ischemic hepatic insut 24b. Wara autopsy findings available prior to complation of cause of death? probable acute tubular necrosis 24a. Was an autopsy hypoxic-ischemic encephalopathy 1 Yes 2 □ No 25. Wes case referred to medical axaminar?

1 Yes 2 No 26. Placa of Deeth (Check only one) Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending investigation 1 Tyes 2 □ No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 Homicida

physician and the buriel-transit that the death certificate be executed P.O. Box 68760. 80 950 signed by t peed is certificate hes director, page 2 this funerel Attanding death.

**Physician** 

**Funeral** 

Director

the Maryland

filed within 72 hours efter deeth with the Manylan Hygiene.
Hygiene.
Wher than "natural", or items 23s or 28s-1 show ant, the Modical Examines must be notified as

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permit. Page Department of Important: If any injury or pace.

**Physician** /Medical

Examiner

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Physician/Medical

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Certification:

29a. Certifier (Check only one)

29b. Signature end titla of cartifier

/Medical

Director

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Completed

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Records, To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu

> State Registrar

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. Licansa number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29d. Date signed (Month, Day, Year)

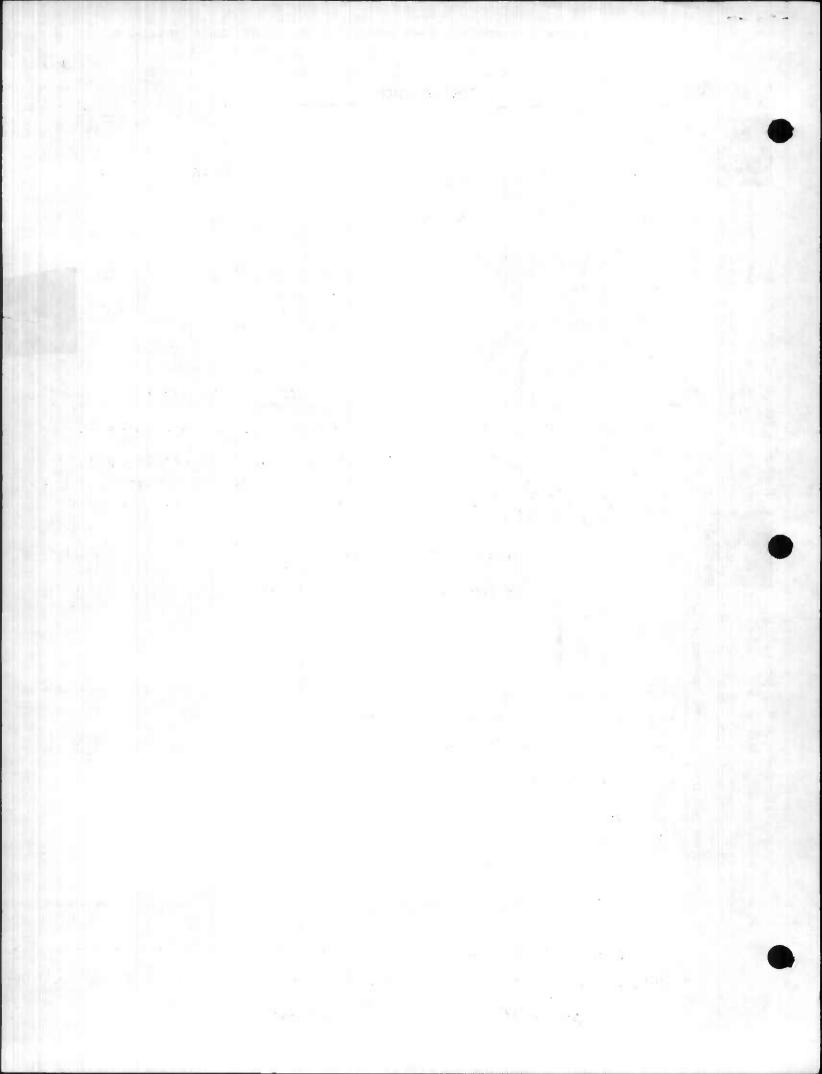
RES-000 Laun lants mo

December 26, 1998

KAREN LANTZ MD

600 North Wolfe Street Baltimore Mayland 21287

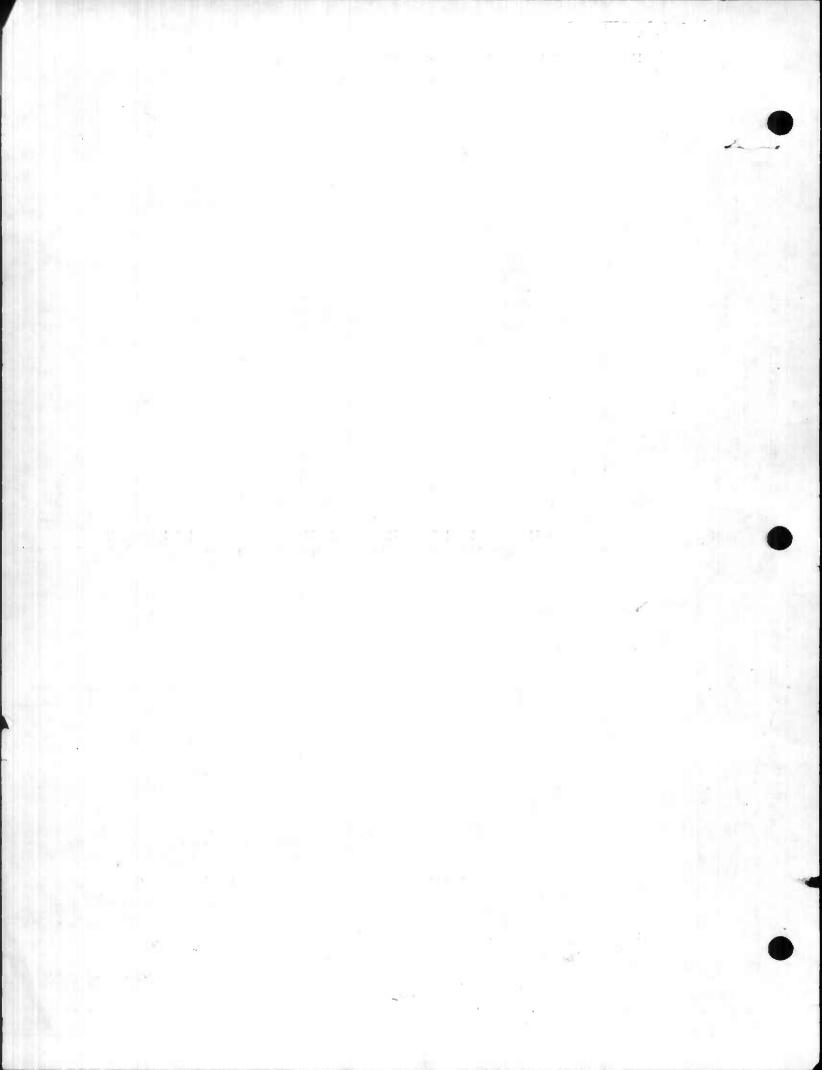
31. Date filed (Month, Day, Year) A 32. Registrar Signature 8 1999



98-7498-033 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 98-294 State of Maryland / Department of Health and Mental Hygiene
#23 PART I, PER MEO G768 2-3-991-11-99 WR
#23 PART 1, 27, 28A-F PER MEO G76 Certificate of Death

Reg. No. CHARLES HUNDLEY ITEM: #23 PART I Reg. No. ITEMS: 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** Charles Alan Hundley DECEMBER 20, 1998 5:10P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6000 WOODYARD ROAD CLINTON PRINCE GEORGES 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country)
Washington, DC 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 10XM 20 F 229-17-3187 34 Yrs. Director May 20, 1964 Usuel Residence of Decedent ahow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Virginia Fairfax County Annandale 1 ☐ Yes 2 ☑ No Director 288-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 United States Items 23a 4616 Willow Run Drive 22003 of America Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes; Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. hours after 1 ☐ Never Merried 2 ☐ Merried altimore. Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 🖾 Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is married other than "reperty injury or other traumatic event, in a Med. PAGE. Elementery/Secondery (0-12) College (1-4or 5+) 12 Building/Construction Carpenter 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Alan Taylor Hundley Josephine Ann Reed 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Josephine R. Brown / Mother Route 2, Montross, Virginia 20a. Method of Disposition
1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date December Alexandria, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 25, 1998 Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Welch Funeral Home Cousan wurud H Montross, Virginia 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervsl Between Onset and Deeth NARCOTIC & COCAINE INTOXICATION COMPLICATED BY CARBON MONOXIDE INTOXICATION **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) NARCOTIC INTOXICATION COMPLICATED BY CARBON MONOXIDE Examiner Due to (or as a consequence of): Examin be executed physician and s the burial-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 88 attending | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Onknown Records, by cate has been significant category. 24b. Were autopsy tindings svailable prior to completion of cause of death? 24a. Was an autopsy Completed 11 Yes 2□No 1 □ Ves 2 □ No certificate Vital Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) SCENE 1 TYes 2 No Certification: To to this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred P After USED DRUGS & Division Found: 4:56 5 Pending 1 Neturel ound: 12-20-98 death. M 1 Yes 2 No investigetion after death Director: / 2 Accident INHALED EXHAUSE FUMES FROM CAR 6 CX Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number of Pural Route Number, City or Town, Stete) W 0 0 D Y A R D , 6000 B L 0 CK 4 Homicide 8 To the Hospital or within 24 hours aft To the Funeral Di completely filled in DIRT PATH CLINTON, MARYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

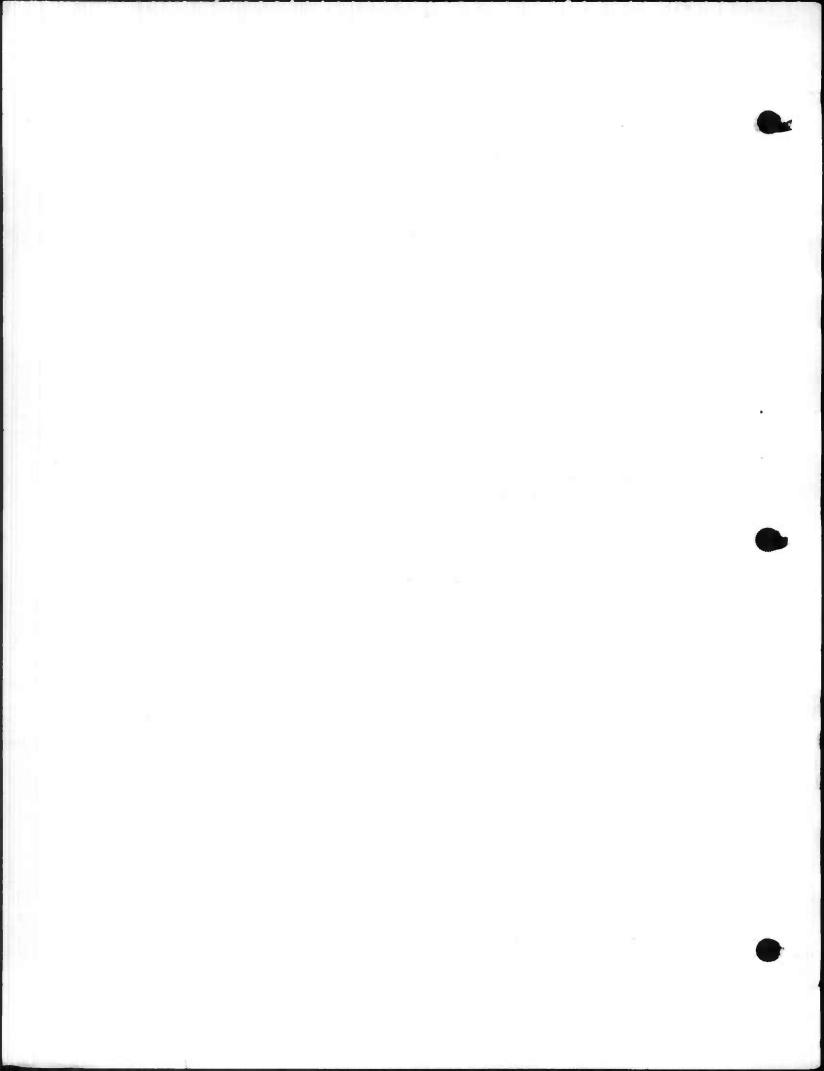
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier edical (Check only one) 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Wellste O.C.M.E. **DECEMBER 21, 1998** 30. Name and sodress of person who completed cause of death (trem 23a) (Type, Print) HARYDRION 111 Penn Street, Baltimore, Maryland 21201 Koner 31. Dete tiled (Month, Day, Year) Registrar's Signature State JAN Registrar



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,	
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	EALTH AND N	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)	WARVE	rer			2. DATE OF DEATH MONTH	"31"	3. TIME OF DEATH		
	m. 1 1/2001		a state i real a state i real			7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country) IRGINIA			
OB	90. FAGILITY NAME (If not institution, give street TUTYRE CARE	1 /	Tomewood. Paltimore				OF DEATH			
DIRECTOR	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION				/	10d. INSIDE CITY			
	MD . N/A		B.	ALTIM	ORE		1 YES 2			
FUNERAL	2503 VIOLET AV			21215				.S. OF A.		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 XWIdowed 4 Divorced	FORCES7 1 YES 2 YNO II yes			DECENDENT OF HISPANIC ORIGIN? (Specify Yea or , specify Cuban, Mexican, Puerto Rican, etc.) YES 2 NO Specify:			No— 14. RACE — American Indian, Black, White, etc. Specify: BLACK		
ETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted)	16a, DECEDENT'S USU (Give kind of work life. Do NOT use rei	done during mo		16b. KIND OF BUS	SINESS/INDUS			
COMPLE	N/A	N/A	NURSES			HOSP				
	17. FATHER'S NAME (First, Middle, Last) THOMAS GARDNE	R				TALIFERR		DNER		
190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street					nd Number or Rural R	oute Number, City or Town	n, State, Zip Co	cle)		
-	MOSES GARDNER  20p. METHOO OF DISPOSITION	(BROTHER)			E AVENU		TO., MD. 21223			
14 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  BALTO., MD.										
						YNN FUNE	N FUNERAL HOME 21215-63			
	23. PART I. Enter the diseases, or con ahock, or heart fallure. Lis	npilcetione that caused it only one cause on e	the deeth. Do not each line.	enter the mo	de of dying, such	ss cerdlec or reapi	ratory srreat	Approximats Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	clommaly le	tu umdan	m0)				>7months		
		7 1 0 4	CONSEQUENCE OF):	7100				711/011/13		
	Sequentielly list conditions, if any, lesding to immediate		CONSEQUENCE OF):					year		
RIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					> 2 years		
2	resulting in desth) LAST		•							
1	PART II. Other significant conditions of	ontributing to death be	ut not reaulting in th	ne underlying	cause given in F	Part I. 24s. WAS AN. PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDIC	Chronic renal failur	Witus Rin	4 4		2)	NO	OF DEATH?			
							1 TYES 2 NO			
SICIAN:	EXAMINER?									
	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY WORK?  1 YES  28c. INJURY WORK?  1 YES			JRY AT	28d. OEŞCRIBE HOW INJURY OCCUREO				
	2 Accident Investigation				ES 2 NO	28t, LOCATION (Street e	d Number or Rural Route Number,			
	4 Homicide determined Duttiding, etc. (Specify)  City or Town, State)									
Z I	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA DISCONDING ONE) 2 MEDICAL EXAMINER: (							euse(e) and manner se stated.		
296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED (Month, Day, M  December 31.							ember 31, 1998			
	J Boston 2018, University Porking & Balto mp 2018									
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE G. So.	ale			dur			



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month JOHNSON December 4e. Fegility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hosp va altemore Sinau If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 6 Sev 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 XF Deys Hours Yrs. 217-54-4633 49 09 M.D 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 4615 Park Heights Ave 1. Maritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 11. Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 1 Yes 20 No If Yes, Give Yeer or Dates: 21215 13. Wes Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuben, Mexican, Puerto Rican, etc.) U.S.A. 14. Rece - American Indien, Bleck, White, etc. 1 Tes 2 No Specify: Specify: Black 16b. Kind of Business/Industry Unk 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working Unik life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unk 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert Johnson Cindy Farley 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code) Cynceray Washington-4615 Park Heights Avenue Baltimore, Md 21215 20b. Placa of Disposition (Name of cametery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State POBunel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Zion cemetery 01/06/99 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset end Deeth Immediate Ceuse (Final IMKNOWN disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): Due to (or es e consequenca of): Part It. Other stgnificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Matural

The law requires that the death certificets be executed the burial-transit and P.O. Box 68760, for use es Records, page 2 should certificate has of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, it Division

Physician/Medical Examiner ò Be Completed 2 Certification:

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/Medical

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filed within 72 hours aftar 21215-0020

Peges 1 and 2 should be filed within nent of Health end Mental Hygiene. ant: If Itam 27 Is marked other than ury or other traumatic event, the Ma

permit. Peges 1 and 2: Department of Health er Important: if Itam 27 is any injury or other trau

**Physician** /Medical

Examiner

altimore, Maryland

2 Accident 3 ☐ Suicide 4 Homicide

(Check only

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cerarying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifies

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

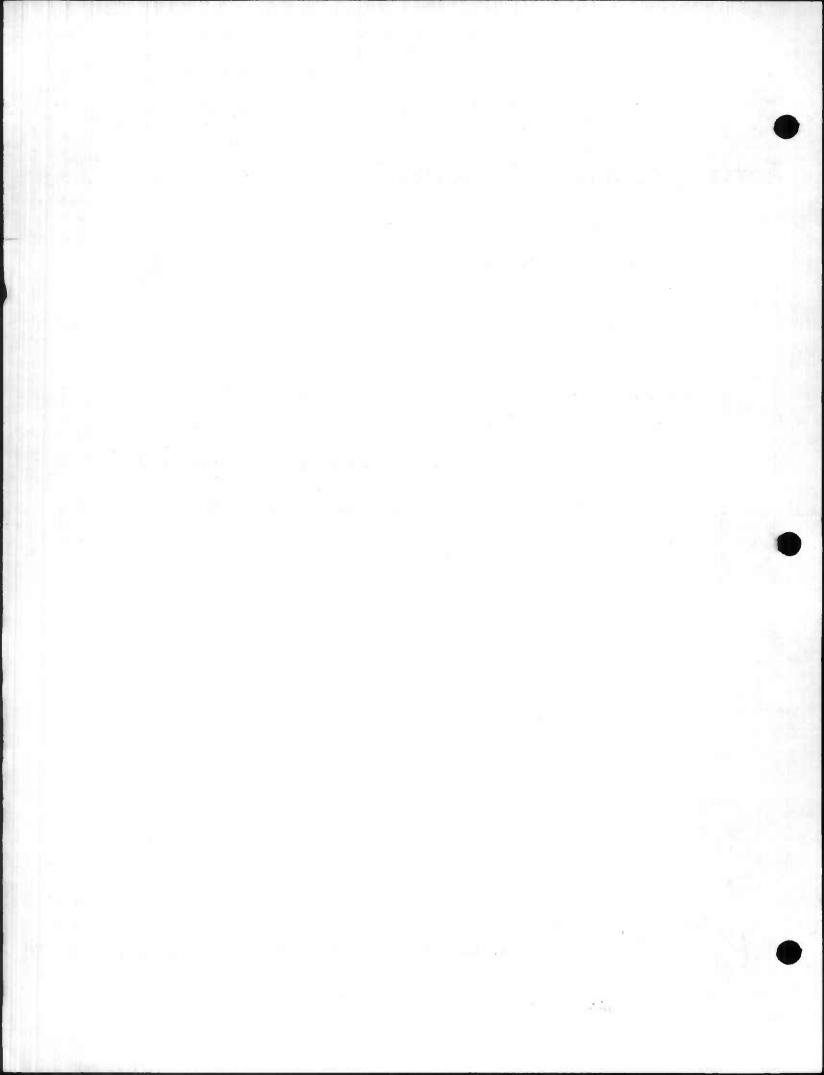
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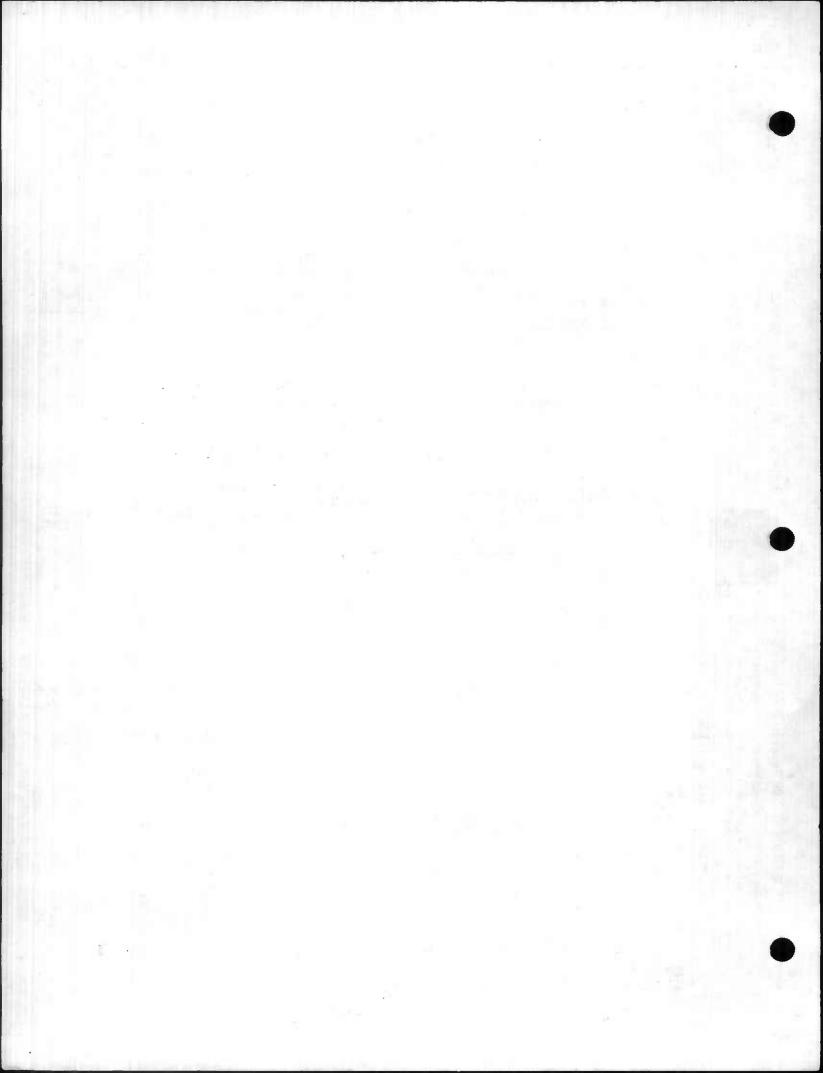
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Registrar

32. Registrar's Signeture 31. Dete filed (Month, Day Year)

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State of Maryland / Department of Health and Mental Hygiene HEMS: #4A, 26 PER PHYSICIAN G767 1-8-99 WICertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 25, 1998 Physician 6:38 am Josephine Krause /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12820 Eastern Avenue COZY COUNTRY RETIREMENT Middle River Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day 1 1924 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1□M 20 F Maryland 74 212 22 3815 Director **Usual Residence of Decedent** the Maryland r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? lied within 72 hours efter death with Hygiene. thygiene after them "naturel; or frams 23s or sirt, the Medical Example on at the 1522 Chesapeake Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White aitimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be lited wit Department of Health and Mental Hygient important: If them 27 is marked other that eny injury or other traumatic event, that once. Housewife Own Home 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Carmen Picarello (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Chesapeake Road Baltimore Maryland 21220 Anna Minossi 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 12/28/98 Baltimore, Maryland 21. Sig ature of Funeral Service Licensee 22. Name and Address of Eacility Bruzdzinski Funeral PA 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. A list only one cause on each line. Approximate Intervat Between Onsel and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner asse physician and s the buriel-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 lan/Medical Due to (or as a consequence of): d for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. á 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b Records. þ 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Was an autopsy performed? Completed 1 Yes 24 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 8 (C)Other (Specify) 2 this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: of standing Faster death.

I Director: After d in by the funer 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ne Hospital or Atta n 24 hours siter de ne Funerel Directo pletely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 1 Corutying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 30. Name and address of person who completed bause of death (Item 23a) (Type, Print) s Signature State 0 Registrar

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98-7399-033 98-284

JAVAR MATHIS

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

the Mandand r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at filed within 72 hours after. Hygiene. Wher then "netural", or its Baitimore, Maryland 21215-0020 pue

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month **Physician** JaVar Pierre Mathis **DECEMBER 16,1998** 4:45A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOLLY HILL DRIVE **ACCOKEEK** PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (Stete or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1 M 2 □ F 241-37-6668 18 Yrs Director **Usual Residence of Decedent** 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Prince George's Clinton 1 Yes 2 No Maryland Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7111 East Clinton Street 20735 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen important: if Item 27 is marked other tha any injury or other traumatic event, 37%, 2006. Merchandise 12 Stock Clerk 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) 8 Deborah Kenan James P. Mathis 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 East Clinton Street, Clinton, Maryland 20735 James P. Mathis /Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State North 20a. Method of Disposition January 1 Burial 2 □ Cremation 3 □ Removal from State Teachey, Carolina Duplin Memorial Gardens 19,1999 4 Donation 5 Other (Specify) 21. Signa ure of Funeral Service Licensee 22. Name end Address of Facility Matthews Funeral Servcie P.O. Box 544, Wallace, North Carolina 28466 Lauser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth Physician tmmediete Cause (Final disease or condition resulting in death) /Medical Wound Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 edical Due to (or as a consequence of): for use as 8 Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 202 No 3 Probably 4 Unknown Records, by cate has been significant, page 2 should b Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy completion of cause of death? TUTYUS 20 NO 1 Yes 2 No certificate Division of Vital Attanding Physician: director 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Xother (Specify) SCENE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred subject shot 1 Natural 5 Pending i or Attanding after death. Director: After d in by the fun 1 Yes 24 No investigation 443 AM 2 Accident 12/16/98 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) | Holly Hill Drive 28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 518 848 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DECEMBER 17,1998 lugen Henry 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute no 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#23b,24a per Phy G767 1/8/98 EW Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Year Month Patricia McBride December 20, 1998 tion of Death 4c. County of Death 4:00 AM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Anne Arundel Sunrise Assistant Living Annapolis If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1□ M 2□ F 155-18-9453 Yrs Aug. 22, 1921 New Jersey Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10c. Citizen of What Country? 800 Bestgate Road 21410 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bieck, Whita, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 Homemaker Own Home 17. Fethar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Stuart Shotwell Beremice Shotwell 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1101 Kalmia Court, Crownsville, Maryland 21032 Tracy McBride/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S 22. Name end Address of Facility State Anatomy Board, 655 W. Baltimore Street Wade Director Baltimore, Maryland 21201 P v11. Enter the disease, or complications that caused the daeth. Do not entar tha mode of dying, such as cardiac or respiratory errest, slock, or heart failure. List only one cause on each line. Approximate tntervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) oSe Due to (of es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): Due to (or as e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 🖾 Unknown 1 | Yes 2 | No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case re examiner? erred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Tursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Yes 2 No

**Physician** /Medical Examiner The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital or Attanding Physician:

To the Hospital

important: if Itam 27 any injury or other tr once.

**Physician** 

/Medical

**Examiner** 

Director

Funerai

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Completed

Be

**Funeral** 

Director

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rithan "natural", or florm 23a or 28a-f ahor the Medical Exempler must be notified at

Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. Ant of Health and Mental Hygiene. At: If Itam 27 is marked other than "natural", or fiel

**Department** 

Baltimore, Maryland 21215-0020

the Maryland

Examiner physician s the burial signed by the a Medical Certification: To After this death. 24 hours after deat Funeral Director: filled in by

þ Completed Be

Physician/Medical

Netural 2 Accident 3 Suicida

4 Homicide

6 Could not be datarmined

28e. Place of Injury - At home, Ierm, street, lactory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signatura and title of entitier

(Check only one)

29e. Certifier

29d. Data signed (Month/Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

12 5/2/00

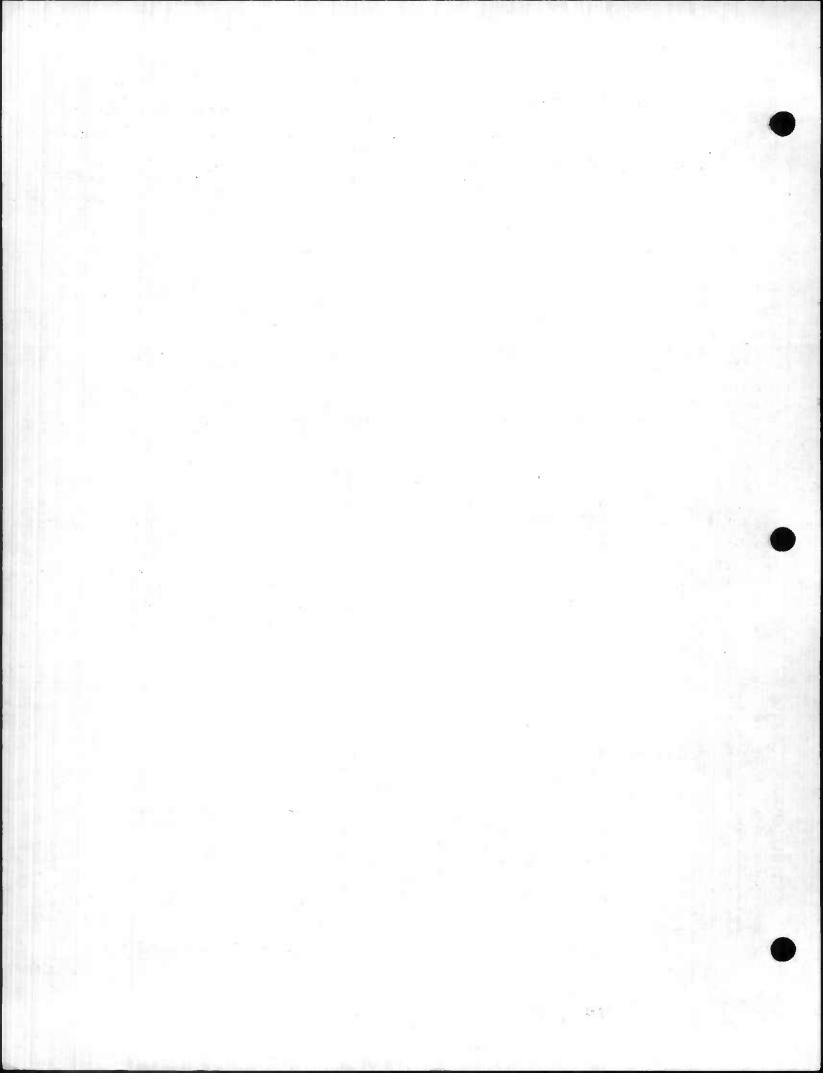
State Registrar

completely

within 2

31. Dete filed (Month, Dey, Year) 1999 JAN

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #17 PER F.H. G768 2-11-99 WR. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Clara 3 1998 0632 Dec 26 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Olney mont mont General 1105P1 70000 F romery If Under 1 Yeer 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete of Foreign Country) **Funeral** Months Deys Hours 1 M 2 LF 579-28-3381 Director 79 Virginia July 19, 1919 Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location Peges 1 and 2 should be filed within 72 hours efter death with the Marylar neat of Health and Mentel Hydinea. In this file marked other than "naturel", or items 23a or 28a-f show this if faming? Is marked other than "naturel", or other traumatic event, the leadest Exeminal mast be notified any 10d. Inside City Limits Yes 2□No Director MD Montgomery Wheaton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12008 Dewey Road 20906 U.S.A. Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, Whita, etc. 11. Meritel Status 1 ☐ Yes 2XXNo If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ \$€XWidowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade com 16e. Decedant's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Otha Grimsley, Jr. SR. Mable Wharton 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia Johnson - Daughter 12008 Dewey Road Wheaton, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Depertment of Important: If eny injury or once. Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/30/98 Culpeper, Virginia 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Clore-Geest Funeral Home 11190 James Monroe Hwy. Culpeper, VA 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or/heert failure. List only one ceuse on each lina. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Ceusa (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examine iclan and burial-transit ens/on The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Dua to (or es e consequence of): 80 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 5.8 Completed 24b. Were autopsy findings avelleble prior to completion of cause of death? 24e. Wes en autopsy performed? pege 2 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 22 ER/Outpatient 3 ☐ DOA this funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Panding investigation s after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) filled in by 4 | Homicida Hospital 24 hours a 29a. Cartifier 1 Certifying Physician: To the best of my knowladga, dasth occurred et tha tima, data and place, and due to the causa(s) and manner as stated.

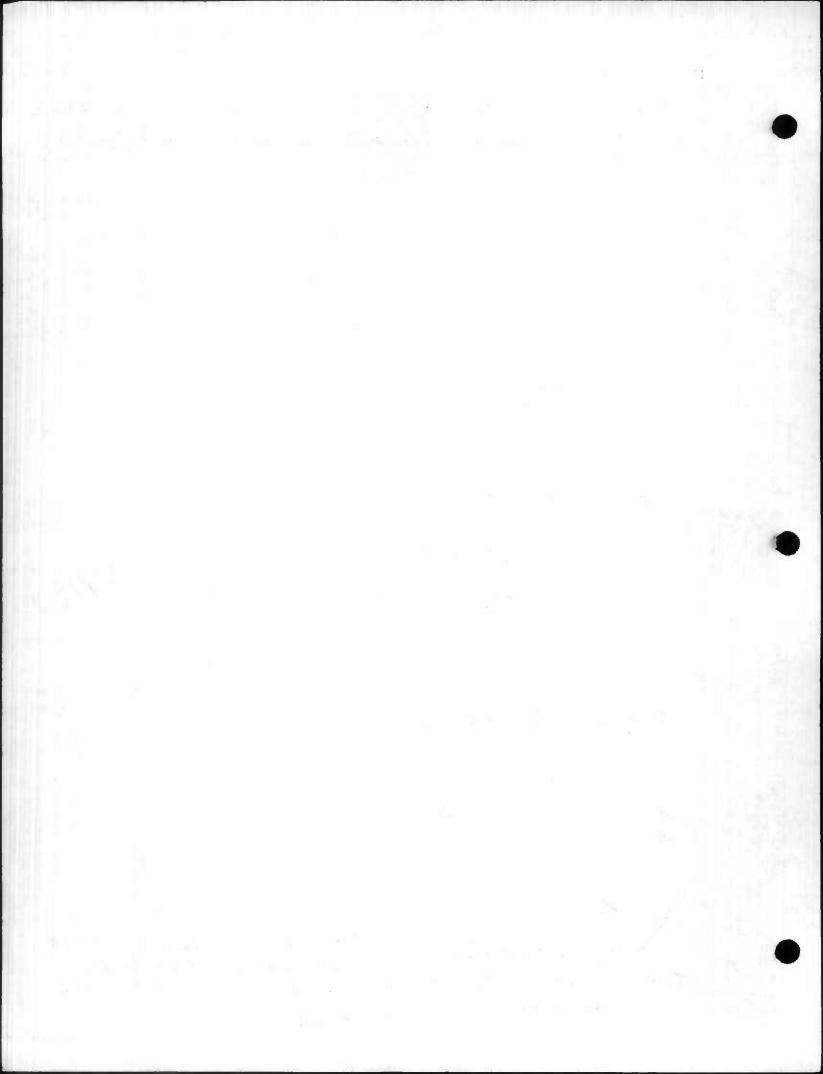
Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et tha time, date end place, and due to the cause(s) end menner stated. To the Hosp within 24 hos To the Fune completely fi Medical 29b. Siar ature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Neme and eddress of parson who completed cause of deeth (Itam 23e) (Type, Print)

BRECHER, MO DIME

32. Registrar's Signature

Spring me



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Caseth **Physician** 31, 1998 Marion M. Procelli December 1:00 A.M. /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rockville N If Undar 24 Hrs. 8. Data of Birth Hours Min. 8. Month, Day, Year) Shady Grove Adventist Hospital

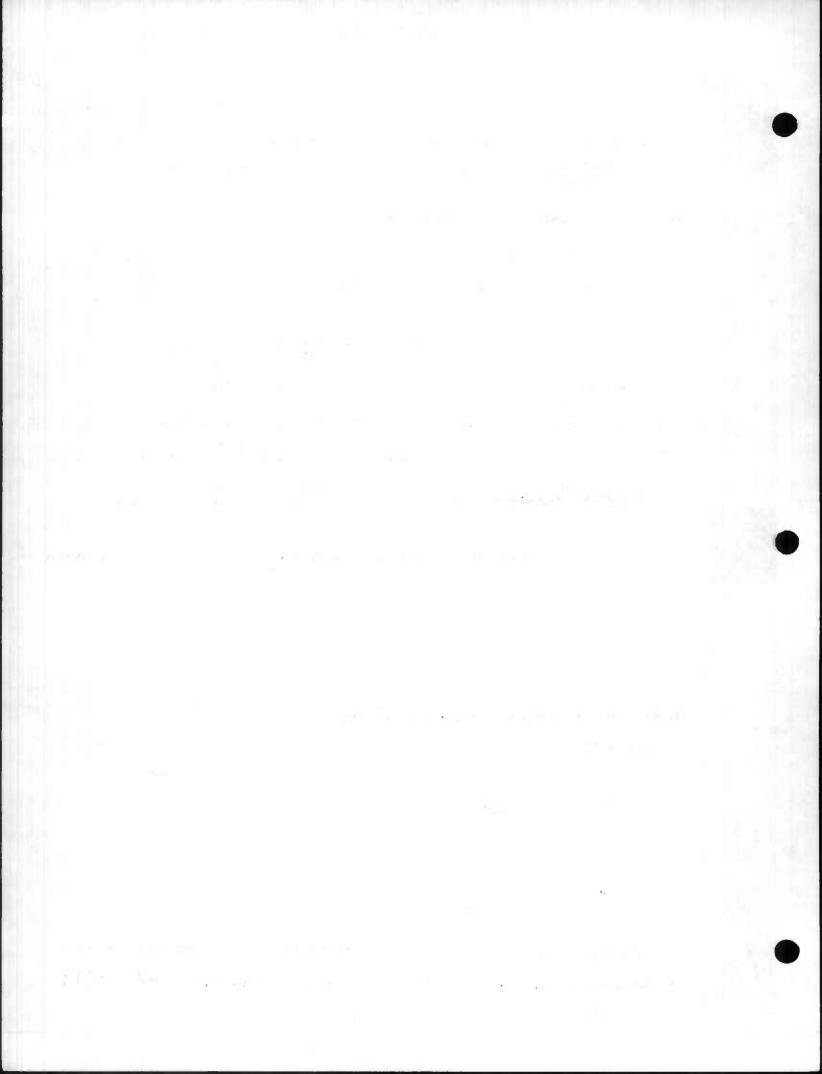
5. Social Sacurity Number 6. Sax 7. Age (in yrs. last birthday) Montgomery If Under 1 Year 9. Birthplaca (Stata or Foreign Country) New York 7. Age (in yrs. last birthday) **Funeral** 1 M 2 XF Months Deys 117-20-8879 72 Yrs Director May 12, Usual Rasidance of Decedent the Marylend 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? deeth with United States 18916 Lindenhouse Road 20879 Funeral of America 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bieck, Whita, atc. filed withIn 72 hours after 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White p 3 Widowed 4 Divorced Yaar or Datas Completed 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) Teacher/ Chairman of 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry th end Mental Hygiene.
7 is marked other than traumatic event, tre Me Elamantary/Secondary (0-12) Collega (1-4or 5+) Education Business Schools permit. Pages 1 end 2 should be file Deportment of Health end Mental Hy Important: If flem 27 is merked other any injury or other traumatic event ODGE. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Thomas A. Mahoney Josephine Wall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Matthew S. Procelli/ Husband 18916 Lindenhouse Road, Gaithersburg, Maryland 20879 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, State January 4 tX Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Saint Mary's Cemetery 1999 Flushing, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Service Licansae 22. Nama and Addrass of Facility Nolan & Taylor-Howe Funeral Home laiser 5 Laurel Avenue, Northport, NY 11768 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Between Onset and Deeth **Physician** /Medical Immediata Causa (Final a nonsmall-cell cancer left lung month diseese or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed pue buriel-tran Sequentially list conditions, if eny, laeding to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated events resulting in death) Last Dua to (or as a consequance of): physician s the buriel P.O. Box 68760. Physician/Medical Due to (or as a consequence of). 88 signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 PYes 2 No 3 Probably 4 Unknown Alzheiner's Dementia, Hyperthyroidism Records. þ Completed 24b. Wara sutopsy findings aveilebia prior to 24a. Was an autopsy ersono gosts o complation of causa of death? page 2 s 1 Yas 2 No 1 Yas 2 No of Vital or Attanding Physicien: filled in by the funeral director, Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) P 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Certification: 28c. injury at Work? 28d. Dascribe how injury occurred After Division 5 Panding investigation 1 Naturai 24 hours after death. Funeral Director: A 1 Yas 2 No 2 Accident 3 Sulcide 6 Could not be 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the Hosp within 24 hot To the Fune completely fi Medical 29a. Cartifiar (Check only one) 29b. Signature end title of certifian 29c. Licensa number 29d. Data signed (Month, Day, Year) 041794 December 31, 1998 Willan Lyer 30. Nama and address of person who complated causa of death (itam 23a) (Type, Print) P. Callahan-Lyon, MP 20879 911 Russell Ave Galthersburg. MO 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 8 1999

Sparks

DHMH 16 Rev 6/95

Registrar

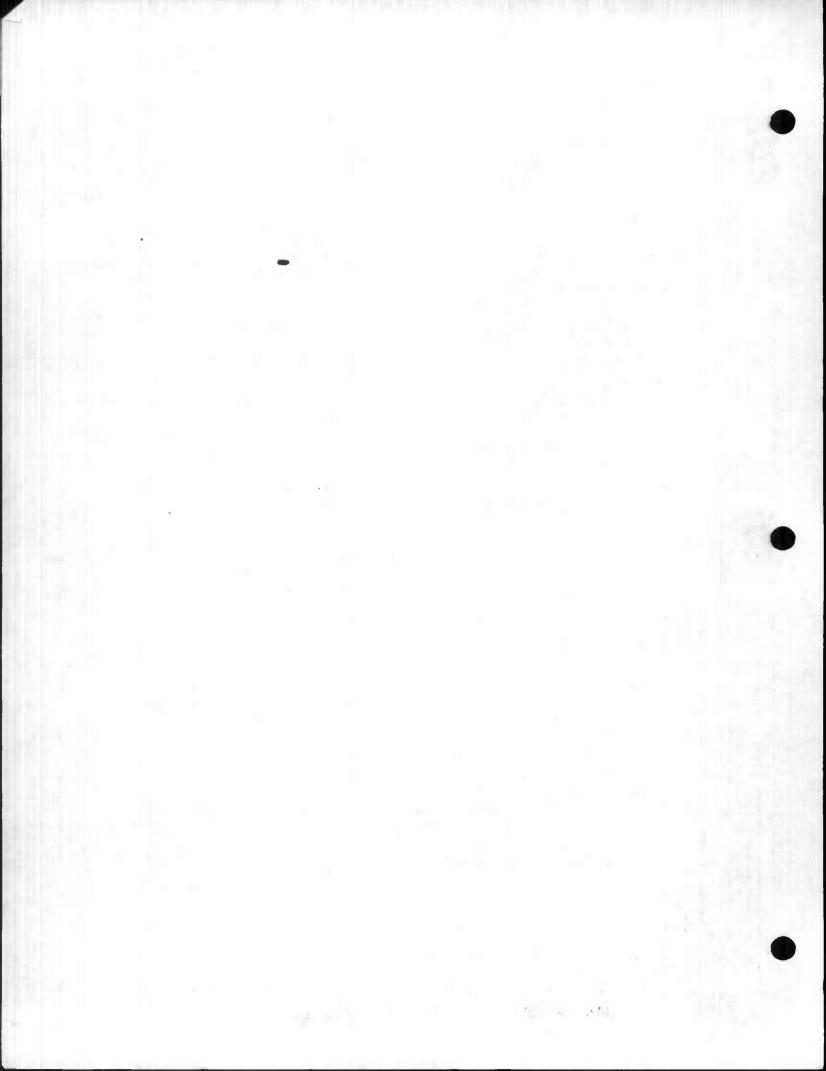
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	Social Security N	-	6. Sex	7. Age	(In yrs. las	st birthday)	If Under 1 Year			. Dete of Birt		0 ,	-	
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30.	Name and addr	ress of person w	vho complete in	motion of dea	ath (Item 2	3a) (Type, F	rint)	0011-				111		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1/6/99 Amend #1, 1/6/99, drw Certificate of Death 1. Decedent's Nama (First, Middle, Last) Sally Louise Christiansen 2. Dete of Death 3. Time of Death **Physician** Dec 24, Louise ---- Sally --- Christiansen 12:20 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death National Lutheran Home Rockville Montgomery If Undar 1 Year | If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) **Funeral**  Birthplace (Steta or Foreign Country) 1 M 2 F 102 Months Days Hours Min. Yrs. Director 579 48 8239 Oct 10, 1896 Norway Usuei Residence of Decedent with the Maryland 10e. Stata 10b. County worle 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f shovididal Examiner must be notified at Director 1 Yas 3 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Veirs Drive Funeral 20850 United States 11. Marital Status Was Dacedent Ever In U,S. Armed Forcas? Was Decedent of Hispanic Órigin? (Specify Yas or No If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Navar Merried 2 Married Yes 2000 21215-0020 1 ☐ Yes 2√DXNo Specify: by Specify: White 3√ Widowed 4 Divorced Year or Detas: Completed the Medical 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry I Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) Society Assistant Section Chief National Geographic other traumatic event. Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental 2 Soren Roed Andersen Ellen Dorthea Nilsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health at important: If Itam 27 is any injury or other trausonce. Elliott Thompson (NEPHEW) 9308 Convento Terrace, Fairfax, Virginia 22301 altimore. 20b. Piece of Disposition (Neme of cemetery, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Dec 26, 1998 Clinton, Maryland 21. Signeture of Funeral Service Licensea 22. Name end Address of Fecility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervai Batween Onset end Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting In deeth) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Undarfying Cause (Disease or Injury that initiated events resulting in death) Lest for use as the bunal-tran Box 68760. the attending physician Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes an autopsy parformed? this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case refarred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how Injury occurred 1 Natural 5 Pending Invastigation death. 1 ☐ Yas 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 - Homiclde 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end manner stated. Medicai 29e. Certifie (Check only 29b. Signature and litie of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year)

Charles W. Karesh, M.D. 26033 Ridge Road, Damascus, Maryland 20872

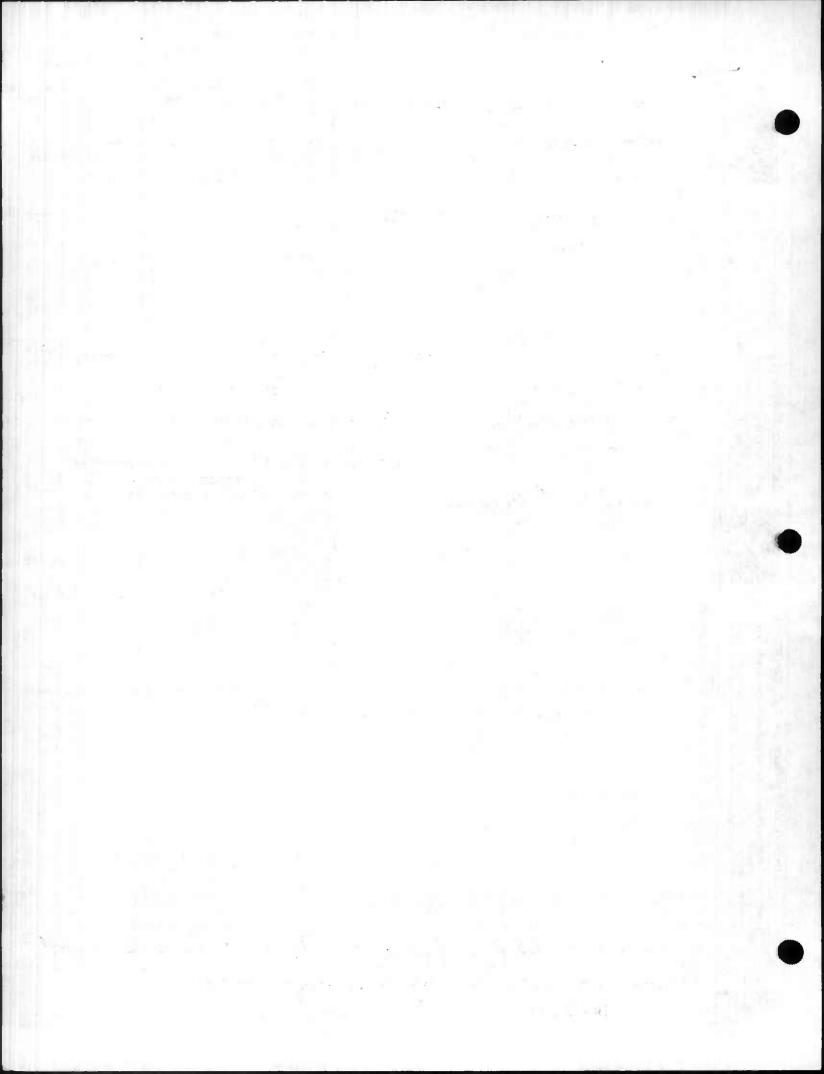
32. Registrar's Signature

Dener

State Registrar 30. Name end eddress of parson who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene

rgio Cimin	i				Ce	ertifica	ate of	Death		Reg. No.	L}	022
		1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath	ALC: U	3. Time of Death
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Funeral			5. Sex 7. A 1 M 2 □ F	ige (In yrs.	last birthday	/) If Und		r If Under 24 Hrs		rth ay, Year)	9. Birthp	lace (State or Foreign
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DIVISION C but or Attending P to a ster death. St Director: Attert led in by the funera Certification.		4 Homicide determin	200. Flace of in	njury - At h	ome, farm, s	treel, fecto	ory, office		28f. Location City or To	(Street and Num wn, State)   ©	iber or Rura	anh Tippett
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		Stephen S. 1. 31. Date filed (Month, Day, Year)	2 adrn+2	tray's Signa	ture	III.	renn	Street,	Battimo:	re, Mar	y.Land	21201
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth Month AMest Josephine Elizabeth Dill Dec. 31 1998 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 303 N. Church Street Greensboro Caroline 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) If Undar 1 Year If Undar 24 Hrs. 8. Deta of Birth (Month, Day, June 15 9. Birthplace (State or Foreign 1908 1 □ M 2 1 F Months Davs Hours 90 218-12-1886 Pennsylvania Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits TX Yas 2 No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 N. Church Street 21639 U.S.A. 12. Wes Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ◯ No It Yas, Giva 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, Whita, atc. 11 Maritel Stetus 1 Navar Merried 2 Married 1 Yas 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) manufacturing seamstress

Etamantary/Secondery (0-12) 10 yrs

17. Father's Nama (First, Middla, Last)

18. Mothar's Nama (First, Middle, Meidan Sumame)

August Brogley

**Physician** 

/Medical

**Examiner** 

**Funeral** 

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Baltimore, Maryland 21215-0020

Lena Kibler Brogley

1/5/99

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) P.O. Box 264 Greensboro, Maryland

Gladys Kinnamon/ daughter-in-law 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State

20b. Place of Disposition (Nama of cematery, cramatory or other place) Greensboro Cemetery 20c. Location - City or Town, Stata

Greensboro, Maryland

4 ☐ Donation 5 ☐ Other (Specify)

22. Nama and Address of Fecility

Fleegle & Helfenbein Funeral Home. PA P.O. Bx 160 Greensboro, MD 21639

23a. Pert1. Enter Me disease, or complications that ceused tha deeth. Do not enter tha moda of dylng, such es cerdiac or raspiratory errest, shock, or haert failura. List only ona ceusa on eech lina.

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Physician/Medical Examiner Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaesa or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence ot):

Part ii. Other significant conditions contributing to death but not rasulting in the undarlying ceuse givan in Part i.

23b. Did tobacco use contributa to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Wara autopsy tindings available prior to completion of cause of death?

1 ☐ Yas 2 No

26. Place of Deeth (Check only ona)

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28a. Data of Injury (Month, Day Year) 5 Pending invastigation

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Hospital:

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28a. Plece of Injury - At homa, tarm, street, tectory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 26d. Describe how injury occurred

28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one)

27. Manner of Death

1 Natural 2 Accidant

3 Suicida

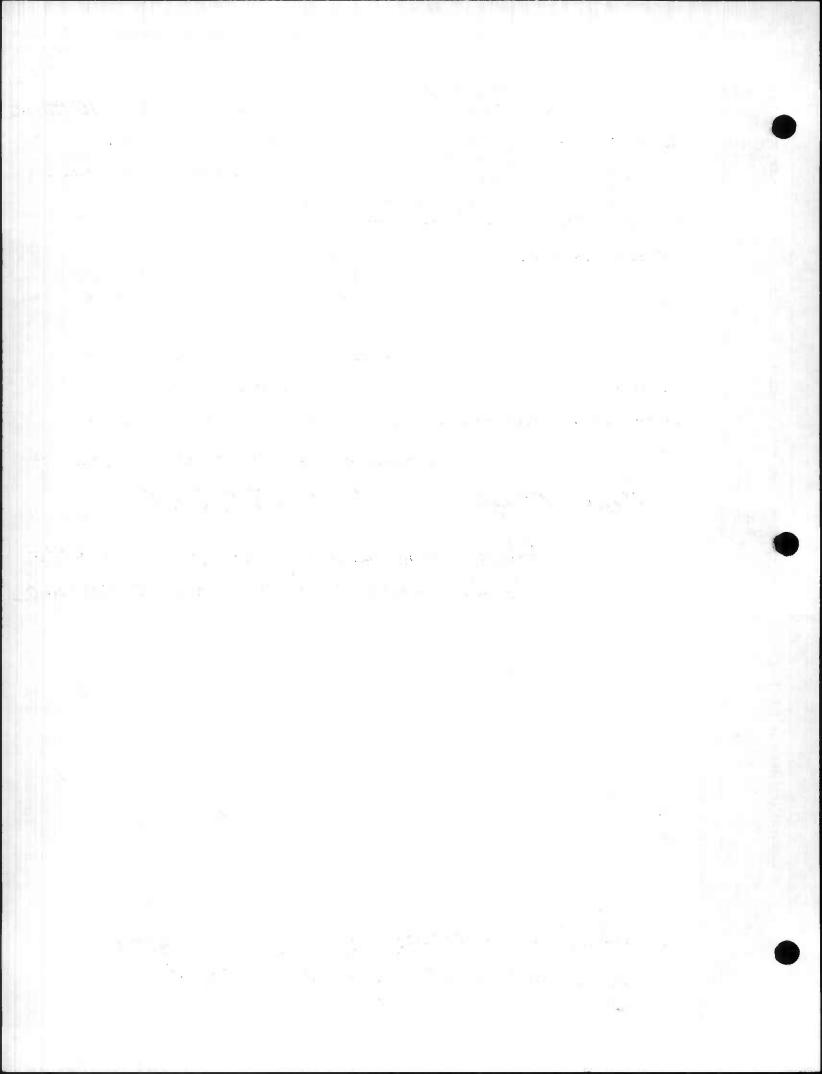
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1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) end mannar as stated.

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Month Year Edward Luther Dove, Jr. 0100 /Medical Dec 25 1998 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shore Nursing & Rehab Center Denton Caroline 5. Social Security Number tf Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Sept 16 1911 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** M 2DF Days Hours 87 Yrs. Director 217-14-7471 Maryland Usual Rasidance of Decedant 10a Stata 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yas 2 No Maryland Prince George Ft. Washington 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7008 Pleasant Hill Drive 207 USA death Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 Yas 2\sum No 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Head of Examinations. 1 Navar Married 2 Marriad altimore, Maryland 21215-0020 If Yas, Giva Yaar or Datas 1 ☐ Yas 2 ☐ No Specify: p Specify: White 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Elamentary/Secondary (0-12) Collaga (1-4or 5+) 07 farmer tobacco 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Edward L. Dove, Sr. Edith V. Anderson Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) William Dove/ brother 9794 Tuckahoe Road, Denton, Maryland 21629 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 12/27 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Greenboro, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Fleegle & Helfenbein Funeral Home, Box 160 Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 1 wh **Examiner** Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Box 68760 Dua to (or as a consequence of) use as ettending P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 900 2 □ No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy complation of causa of death? TUYES 20 NO certificate TLYes 2 No Division of Vital or Attending Physician: director. Be 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 25 No Certification: To this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After Naturai 2 Accidant 5 Panding Invastigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

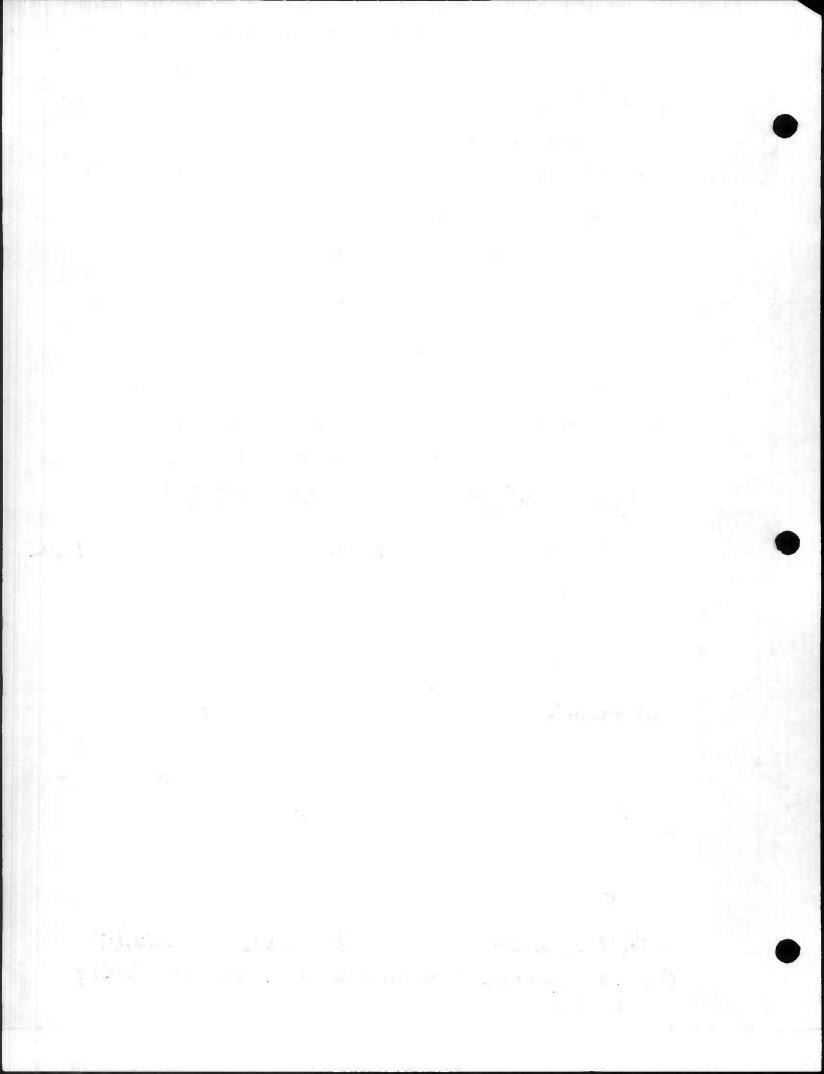
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only \$ 29b. Signature and title of certifiar 29d. Data signed (Month, Day, Year) 29c. License number

32036

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)
Com J. Sprovie 2108 P. Donah Drive Cluster, Mrs 21619

packy

32 Registrar's Signatura



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #12, 28 years, 1/6/99, drw 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death George R. Donley DECEMBER 24, 1998 3:10 P.M. 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 8. Sex Birthplace (State or Foreign Country) Months Days Hours Min 579 52 2089 88 July 30, 1910 Pennsylvania Usual Residence of Deceden 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD P.G. Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4410 Ridgecrest Drive 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 1942 \*\*Noves 2 | No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Meritel Status Biack, White, etc. 1 Never Married XIX Married 1 ☐ Yes Ž\No Specify: 3 ☐ Widowed 4 ☐ Divorced White years 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Eiementary/Secondary (0-12) Coilege (1-4or 5+) 12 Colonel U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Raymond Donley Anna Lieber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy L. Donley (WIFE) 4410 Ridgecrest Drive, Suitland, Maryland 20746 20b. Piece of Disposition (Name of cemetery, crematory or other place) Dec 30, Pag 98 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final 3 YEARS a STAGE DUKES TWO PROSTATE CANCER METASTATIC TO BONE diseese or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy aXI No 1 Ves

**Physician** /Medical Examiner

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Peges 1 and 2 should be filed within 72 hours after death tent of Heelth end Mentel Hygiene.

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Funeral

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Completed

Be

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with

AME: GEORGE RAYMOND DONLEY altimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Physician/Medical

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 T Homicida

1 ☐ Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 1 ☐ Yes

28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

ti\_KCertifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifie

5 Pending investigation

6 ☐ Could not be determined

PA MD- 058405- L

29d. Date signed (Month, Day, Year) DECEMBER 24, 1998

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) 89 MDG/1050 W PERIMETER RD ANDREWS AIR FORCE BASE, MD 20762-6600

ALAN PERLMAN, CAPT, USAF, MC 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 3

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month 03:15PM **Physician** Duthie Alvce DECEMBER 27, 1998 /Medical 4c. County of Deatl 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner GEORGES MARYLAND HOSPITAL CENTER CLINTON PRINCE SOWHERN If Under 24 Hrs. 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M M F 93 Director 579 05 3895 Aug 20, 1905 Michigan Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at P.G. 1 ☐ Yas 2 No Brandywine Directo MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 12201 Cedarville Road Funeral 20613 UNITED STATES death 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours efter Yes 2 No f Yes, Give 1 Never Marriad 2 Married Maryland 21215-0020 1 ☐ Yes 12 No Specify: SpecifyWhite à 3 Widowed 4 □ Divorced Vaar or Datas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed w thent of Health and Mental Hygien tant: If item 27 is marked other ti lury or other treumstic event, to 12 Union Station Hostess 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Melden Surneme) Be Adelbert O. Cook Emma Wilcox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Keith Sherwood (FRIEND) 12201 Cedarville Rd, Brandywine, Maryland 20613 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial ★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of Important: If eny injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory December 29, 1998 Clinton, Maryland 21. Signat of Funer I Service Licensee 22. Nama and Addrass of Facilities Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 26a. Part 1. Friter the disease, or complications the Levi sad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final ASPHYXIA (CHOKED ON BOLUS OF FOOD) disease or condition resulting in death) Examiner Due to (or es a consequence ot): Examiner ARTORUSCURROTTIC CARDIOVASCULAR PISENSE Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last Bud burial-tran Due to (or es a consequence ot): certificate be execu physician s the burial P.O. Box 68760. Physician/Medical Dua to (or as a consequence ot) USB 85 attending 0 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed I Records, þ 24b. Were autopsy findings available prior to 24a. Was en autopsy Completed peen completion of cause of death? page 2 2 KINU TC Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 10 1 Yes 2 No this funeral 27. Manner ot Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After CHOKED ON BOLLE OF FOOD 1 Naturai 5 Pending investigation Injury at or Attending a after death. 12-27-98 02:46PM 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) FRAND YWIN E 12201 CEPERVILLE MARYLAND 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours at Funeral D HOME 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as statud.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated. edicai 29e, Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifiars 29c. Licansa number DIME DECEMBER 28, 1998 dress of person who completed cause at deeth (Item 23a) (Type, Print)

3001

32. Registrar's Signature

HOSPITAL

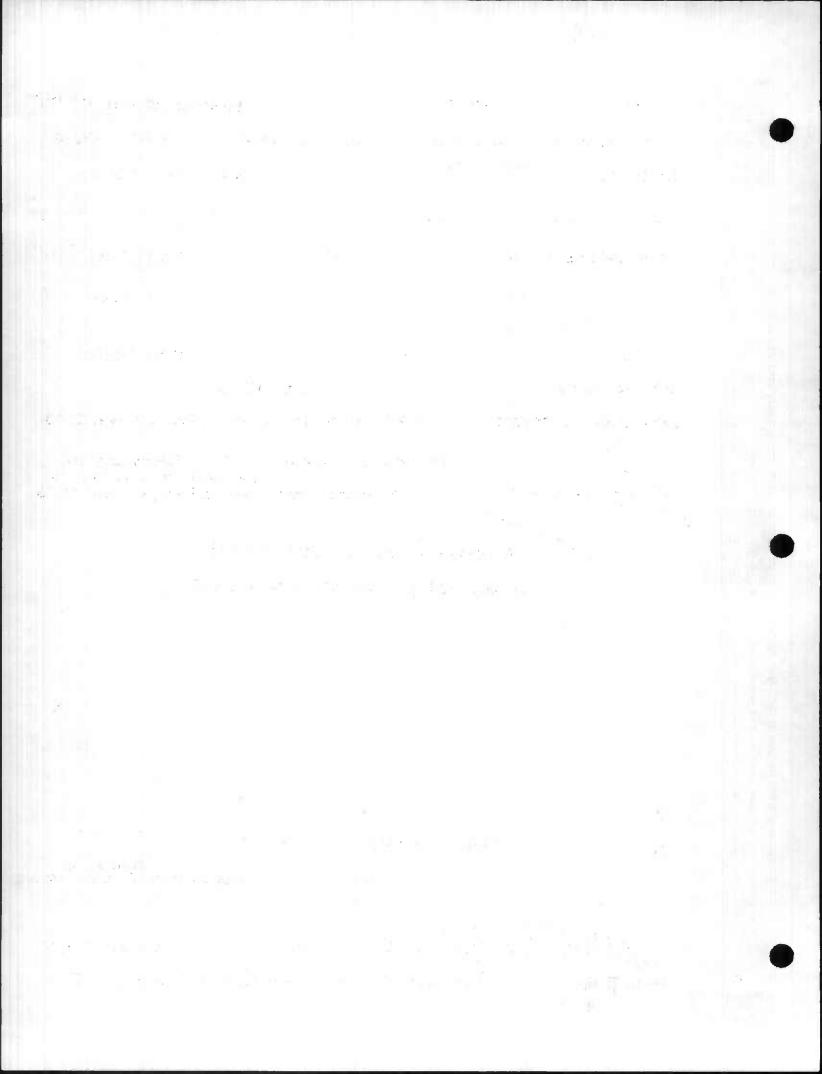
DRIVE,

CHEVOLLY, MARYLAND 20785

State Registrar MARIO

31. Date filed (Month.

GOLLE



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State of Maryland / Department of Health and Mental Hygiene 8 4 1 2 7

						Cert	ificate	e of	Death			Reg. No.	-7	U time 1	
	Physic		1. Decedant's Name (First, Middla, La Howe E		on						2. Deta of Dea		1 <b>39</b> 8	3. Time of 9:20	Death P.M.
	/Medi Examii		4e. Facility Nema (If not institution, giv Spa Creek Cent						4b. City, To		ocation of Death	4c. County		de1	
	Funeral Director		5. Social Sacurity Number  218-14-3041  Usual Rasidance of Decedant	Sex 7. Age	a (In yrs. last bii 77		If Under 1 Months	Yeer Deys	If Under	24 Hrs. Min.	8. Data of Birt May Day	<sup>h</sup> . <b>19</b> 21	9. Birthp	olece (Steta or Viand	r Foreign
	Maryland a-f show	ctor	10a. Stata 10b. County  Maryland Anne Art	unde1	10c. City, Tow		ation Side	2					11	0d. Inside Cit	
	23a or 28 ust be no	Funeral Director	10e. Street and Number 5966 Shady Side	e Road		٠	10f. Zlp (	00de 0764	<b>4</b>		10g. Citizan ot Whet Co			itry?	
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examiner must be notified at			11. Meritel Status  1 □ Navar Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 Yas 2X N If Yas, Giva Yaar or Detes:			7	7	lispanic Origan, Maxicen Specify:	ispanic Origin? (Specify Yas or No- in, Maxicen, Puerto Rican, atc.) Specify:		14. Rece - American India Bleck, White, etc. Specify: Black		etc.	
15-0	natur	eted	15. Decedant's Ed (Specify only highest gra	ducetion tda completed)	16a.	Deceda (Give ki	nt's Usual ind of work	Occup	oation during most d)	t of work	ing	16b. Kind of B	usinass/inc	Justry	
212	withir ione. then	Completed by	Elamantary/Secondery (0-12)	Collega (1-4or 5	+)		armer		d)			Farm	ing		
pu	other other	Be C	17. Fathar's Name (First, Middla, Last)	)					18. Motha	r's Nam	a (First, Middla,	Maidan Suman	ne)		
ylai		ToE	Richard	East	on	31			He1e	en		You	ng		
	D = F =		19a. Informant's Name/Relationship ( Lucille Easton/W		59	66 S	hady	Sid	de Roa		Shady S				
Baltimore,	permit. Pages 1 and Department of Heat Important: If Itsm 2 any injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		20b. Plece or cemata. Bethel					12	Data 2/28/98	Huntin	-		
Balt	pemit. Departi Import any inj		21. Signature of Funerel Service Licer Medyn a.	1 1 1					ss of Fecility Beach	DC.	well Fun ad Princ			, MD 2	0678
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	/Medical Examiner	16	Immediate Causa (Final disease or condition resulting in death)		ENAL Dua to (or es a									5 y.	R
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Records,	has b	Completed	CONO	estive	Hen	nT		EA	アノノノ	Re.		an autopsy rmed?	OOT	are autopsy tir alleble prior to mpletion of ca death?	)
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Divis	2442	Certification:	3 Suicida 6 Could not be datermined	28a. Plece of Inju building, atc.	ry - At home, fe (Specify)	rm, strea	it, factory,	office			28f. Location (5 City or Tow	Street end Numb m, Stata)	per or Rura	l Route Numb	oer,
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State of Maryland / Department of Health and Mental Hygiene Q

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Dhye	olan	1. Decedent's Name (First, Middla, La	est)				2. Dsta of Deal Month	th Dey	3. Time of Desth	
Physi /Med		DONALD CARL G	ATEWOOD, S	R			Decembe:			
Exam		4e. Facility Nema (If not institution, give	re street and number)			4b. City, Town, or L	ocation of Death	4c. County of	of Desth	
		Calvert Memoria	l Hospital			Prince Fr	ederick	Cal	vert	
Funera Directo		5. Social Sacurity Number 8. S 579–30 0636	Sex 7. Aga (In	yrs. last birthday) 70 Yrs.	Months Deys		8. Data of Birth (Month, Day)	Year) 8.1928	9. Birthplece (State or Foreign Country) Washington, DC	
/land		Usuai Residance of Decedant 10a. Stata 10b. County	10	c. City, Town or Lo	ocation			07.520	10d. Insida City Limits	
ha Man 28a-f sh outfied	Director	Maryland Calvert	=	Hunting					1 ☐ Yes 2 🔀 No	
h with t	al Dir	10e. Street and Number 3571 Deep Landing	Road		10f. Zip Coda 20639-	9554		og. Citizen of W nited Si		
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A 1 A 1 D-UU ZU d within 72 hours af glena. rr then "natural", or	Completed	15. Decedant's Ec (Specify only highest gra Elamantary/Secondary (0-12)	ducation ade completed) Collega (1-4or 5+)		16a. Decedant's Usual Occupation (Give kind of work done during most of wo lifa. DO NOT use retired)				siness/Industry	
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로 모르다 라		Gloria V. Gatewoo	od, /wife	same	as 10	t and Number or Ru	rai Houta Number	; City or Town, s	stata, ZIP Code)	
		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State		matory or other pla emetery		2/30/98	Barsto	City or Town, Stata W, Maryland	
permit. Pages Department of Important: If It any Injury or		21. Signetura of Funarei Sarvice Licer	Beg )	83	2. Neme and Addr 325 Mt. Har	<sup>ass of Fecility</sup> Rat mony Lane,	usch Fund POB 100, C	eral Hor Wings, M	ne,P.A. 0 20736	
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requires that the death ceree isgned by the attendir	by Ph						1 🗆 Y	es 2√√No	3 Probably 4 Unknown	
	Completed						24a. Wss a perform	n sutopsy ned?	24b. Wera sutopsy findings sysilable prior to completion of cause of death?	
F # 8	S						104	s 2⊠No	1 Yes 2 No	
Iclan: T		25. Wss casa refarred to medical	17				th (Check only on	6)		
	Be	axaminar?	Hospital:	2 ER/Outpatier	nt 30X DOA	har: 4□ Nursing Ho	oma 5 ☐ Raside		r (Specify)	
hysic his ce	2	1 ☐ Yas 2 🔀 No	1 U Inpatiant					ascribe how injury occurred		
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DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 4:30 A.M Grimes Richard Dec 29, 1998 Thomas /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5508 Yorkshire Drive Temple Hills P
It Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Prince George's If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 10 M 20 F **Funeral** Days Months 93 577 60 2724 Director Dec 4, 1905 Washington DC Usual Residence of Deceden the Manyland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yas XX No Director P.G. Temple Hills 10g. Citizen of What Country? 10e Street and Number 10f. Zlp Code with 5508 Yorkshire Drive 20748 United States Funeral 72 hours after death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Maritai Status Black, Whita, atc. 1 Nevar Married 2 N Married 1 ☐ Yes 2 TNo Specify: p 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usuei Occupation (Give kind of work dona during most of working life. DO NOT use retired) traumatic event, the Madical 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7; Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Cartologist U.S. Postal Service 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Henry T. Grimes Lillian A. Haar 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Ann Grimes (WIFE) 5508 Yorkshire Drive, Temple Hills, MD 20748 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Jan 2, 1998 Suitland, Maryland 21. Sig re o Funaral Sarvice Licensas 22. Name and Address of Fecility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Part. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not k, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physician** CUTE MYOCARDIAL INFARCTION /Medical immediate Cause (Finel disease or condition resulting in death) Examiner RTERIOSCLEROTIC HEART DISEASE Examiner the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initieted events rasulting in death) Last and ARTERIOSCLEROTIC CEREBROVASCULAR DIS. physician Physician/Medical the Due to (or as a consequence ot) ed by the detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 0 signed by t 1 Yes 2 No 3 Probably 4 Unknown SPONDYLOSIS that þ requires 24b. Ware autopsy findings available prior to should a 24a. Was an autopsy performed? Completed completion of cause of deeth? Wel has The 22 No certificate 1 Yes 2 No of Vital Physician: 25. Was case reterred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 this funeral 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 5 Pending investigation Attending Division ours effer deep.

V Director: Ah.
in by the fire 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the 3 ☐ Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) edical 1 Certifying Physician: Το the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medicat Examinar: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number Dec 29, 98 30. Name and address of person who complated causa of weth (tter 23a) (Type, Print) 15 R. A. McConnaughy, M.D. 11418 Livingston Rd, Fort Washington, MD20744 31. Date tiled (Month, Day, Year) 32. Registra/s Signeture State DEC 3 0 Dener Registrar

DHMH 16 Rev 6/95

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 22 is marked other transmit and natural; or thems 23s or 28s-f show any injury or other traumatic event, the Medical Elements must be notified at once.

To Re Completed by Eliperal Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

State Registrar 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Day, Year)
DEC 2 8

Dr. Paul v. Pomilla, M.D. Prince Frederick, MD 20657

32. Registra/s Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? ITEMS: #5 PER F.H. G767 1-15-99 WR. Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Month Vest **Physician** VIRGINIA CHARITY HOSSELRODE December 24, 1998 1732 /Medical 4a Facility Nama (If not Institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Pr. Frederick
If Under 1 Year | If Under 24 Hrs. | 8. Deta of Calvert Memorial Hospital
clal Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Calvert 5. Social Sacurity Number 3 3 7 6 Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Funeral Days Months Hours 10 M 35 Director 578-54-<del>3379</del> 56 12/2/42 Leesburg, VA Usual Rasidance of Decedant the Merylend 10a. Stata 10c. City. Town or Location 10d. Insida City Limits 10b. County d 2 should be filed within 72 hours after death with the Menylen It and Mental Hygiene. 7 is marked other than "naturel", or items 23s or 28s-4 show treumstic event, in Medical Examine must be notified at 1 ♥ Yas 2 No Directo Calvert Huntingtown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4040 Hidden Hill Drive Funeral 20639 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 15 No if Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Navar Marriad Married altimore, Maryland 21215-0020 1 ☐ Yas ② ☐No Specify: Specify: by 3 Widowed 4 Divorced White Completed 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) civil Computer Programmer enginee
18. Mother's Neme (First, Middle, Meldan Sumame) engineering 17. Fether's Neme (First, Middle, Last) . Peges 1 and 2 should be filk timent of Health and Mental H-tant: If item 27 is marked oth jury or other treumatic even Be 10 John Shelby Cole
19a. Informant's Name/Ralationship (Type, Print) Charity Bolt

19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Edward Hosselrode/spouse e 4040 Hidden Hill Drive, Huntingtown, MD
20b. Place of Disposition (Nema or cematary, crametory or other place)

Data

20c. Location City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata permit. Pege Department of Important: If eny injury or page. 4 Donation 5 Donat (Specify)entombment S. Memorial Gardens 12/30/98 Dunkirk, MD 21. Signature of Fu and Service Licensee 22. Nama and Addrass of Facility Raymond Funeral Home 23a. art1. Erver the disease, or complications by traused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onsat and Death Physician /Medical Immediata Causa (Final disaasa or condition resulting in deeth) of Carcinoma Examiner Dua to (or as a consequence of) Examiner physician and the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760 Physician/Medicai Dua to (or as a consequence of): 8 use P.O. ed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t by Records, 24b. Were autopsy findings available prior to completion of cause of death? should I 24e. Wes an autopsy performed? Completed certificate has b 1□ Yes Jahro 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Deat 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: After Netural 5 Pending ne Hospital or Attending n 24 hours after deeth. ne Funeral Director: Afte 1 Tyes 2 No 2 Accidant Invastigation 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 - Homicida edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

名り State Registrar DR. DAVID J TARDIO, M.D. Prince

31. Date filed (Month, Day, Year)

32. Registrar's Signetura

30. Nama and address of person the complated causa of death (itam 23a) (Type, Print)

B. Sparks

Prince Frederick, Maryland

047610

20678

December 24 1998

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Veer Carolyn Lankford Ireland Dec 26 1998 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 13530 Olivet Road Lusby Calvert If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplece (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Months Days 1□ M 2□ F 73 Yes 220 16 5383 Nov 27 1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Lusby 1 ☐ Yes 2 ☐ No Maryland Calvert 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13530 Olivet Road 20657 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 3 □Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondary (0-12) own home homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Eugene Lankford Alice R. Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lynda Ireland- daughter 13530 Olivet Rd. Lusby, MD 20657 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Olivet Cemetery Dec 29 1998 Lusby Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signeture of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD20676 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) RENAL FAILURE Due to (or as a consequence of) Due to tot as a consequence of Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? DISORDER 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

permit. Peges 1 and 2 st Department of Health and Important: If Item 27 Ia n any Injury or other traun once.

**Physician** 

/Medical

**Examiner** 

10a. Stete

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or flows 23s or 28s4 show traumatic event, the Majo cal Examinar maint be notified at

the Maryland

with

72 hours after deeth

2 should be filed within and Mental Hygiene.

3altimore, Maryland 21215-0020

and attending physician for use es the burie ed by the a signed by 8 peen :

Compl

Examiner

Physician/Medical

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Be

2

Certification:

Medical

29b. Signature and title of certifier

Mund

Dener

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Peter L. Wisniewski, M.D. 13
31. Date filed (Month, Dey, Year) 32. Registrar's Signature

DEC 2 8 1998 >

npletely

certificate has this funeral

The law requires that the deeth certificate be executed Box 68760. o ۵. Division of Vital Records, Attending Physician: To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After I filled in by

> State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. CHRONIC SEIZURS 25. Was case referred to medical examiner? Hospitei: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of injury 28d. Describe how injury occurred 28c. injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 Homicide 29e. Certifier 1 Crettfying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as steted. (Check only one) 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner steted.

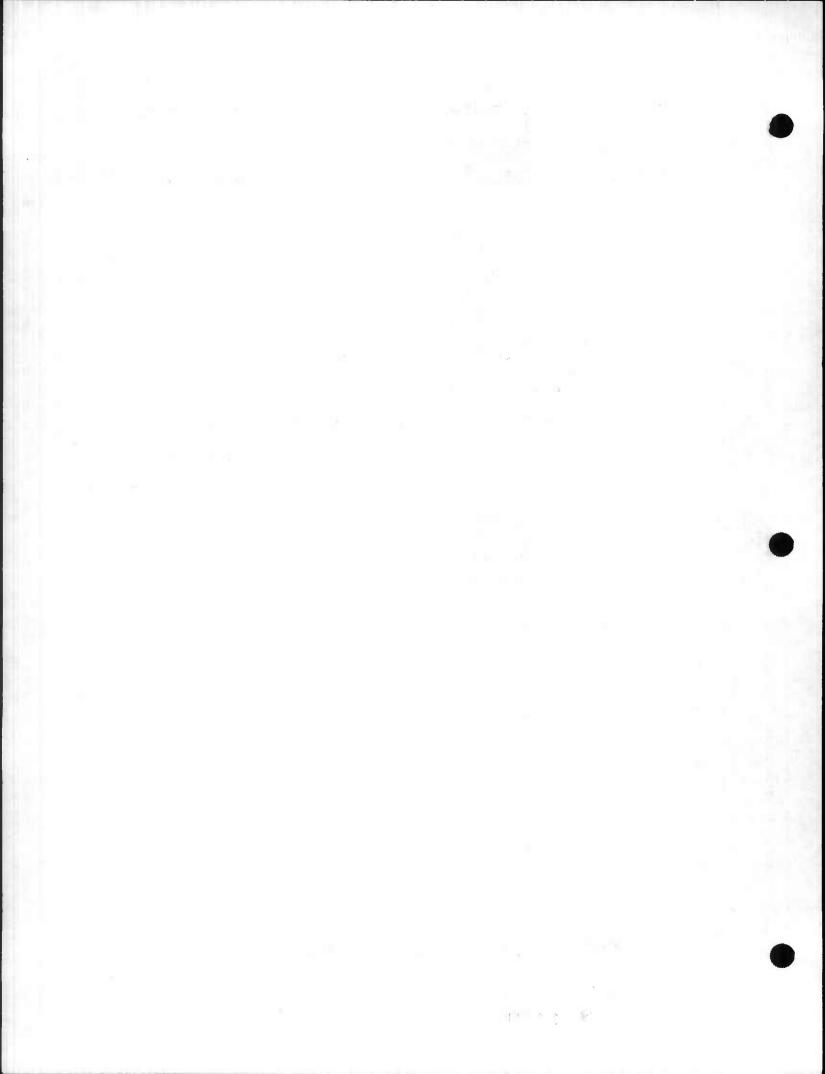
29c. License number

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spaiks

Prince Frederick MD 20678 110 Hospital Rd. Suite 310

29d. Date signed (Month, Day, Year) Dec 28 1998



# Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible.

	TF 1	PA, Alice E., 12	2/29/98		Cert	ificate of			giene 8 Reg. No.	-3	000
Physic		Decedant's Neme (First, Middle, Last     JOE BRA	ADFORD	JON	IFC			2. Date of De Month	Dey	Yaar	3. Tima of Death
/Medi Exami		4a. Facility Nama (If not institution, give			AE'S		4b. City, Town, or	Decemb Location of Deet		998 of Death	5:00 a.m
		1105 Doris Drive					Owings		Cal	vert	
Funeral Director		200 34 4024	ex 7. A MM 2□ F	Aga (In yrs. last 63	birthday) Yrs.	if Undar 1 Yaar Months Days	If Undar 24 Hrs Hours Min.		th y, Year) 1935	9. Birthp Coun Geor	aca (Stata or Forei iny) 'qia
and **		Usuai Rasidence of Decedant  10a. State 10b. County		10c. City, To	own or Loca	ition	7			10	Od. Inside City Limit
the Marylan 28e-f ehow	ō	Maryland Calver	t				ings				1 ☐ Yas 2 🔯 N
or 28e	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Coun	try?
th with	a D	1105 Doris Drive				20	736		U	SA	
after dea or items	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedan Armed Forcas 1 X Yes 2 E If Yes, Give Yaer or Detes	?	10	as Decedent of H ras, specify Cub	lispenic Origin? (S an, Maxican, Puer Specify:	(Specify Yas or No- erto Rican, atc.)  14. Race - American in Bleck, White, atc.  Specify: Whit			ntc.
72 hours natural',		15. Decedent's Ed	lucation		Sa. Deceder	nt's Usuel Occup	pation	41	16b. Kind of Bu		
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id be i ental i ked or	To Be	Ollie		Jone	S		Margre		weiden Sumam	°) Car	nes
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permit. Pages Department of Important: If it any Injury or once.		4 □ Donation 5 □ Other (Specify 21. Signeture of Funeral Service License		ric. I		ny Cemet Neme end Addra		12-24-9	3 Owing	s, ML	)
885 8		William &	Xon	3	Ra	usch Fu	neral Ho	mo D A	, Owing	~~ N	D 20736
Physician /Medical Examiner		23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only of Immediate Cause (Final disease or condition resulting in death)	_							le	Approximate Interval Between Onset and Death
requires that the death certificate be executed een signed by the attending physician end hould be detached for use as the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause Disaese or inlury that initiated events resulting in death) Last	e. Pros	Due to (or as	a conseque	ince of):	onary	Meta	stases		1 year
death certifications at the desired as as	by Physician/M	Pert ii. Other significant conditions co	d	but not resulting	n in the cond						
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2 s Z		CMOME DOTTE	uerve	Llung	Dis		en In Part I.	1 ☐ 24a. Wes		3 Prob	ebly 4 ☐ Unkno
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Yeer IRENE KRALY R 18,98 4c. County of Deeth DECEMBER 7:20pm 4e. Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 2505 Oak Glen Way Forestville Prince George's If Undar 1 Year If Undar 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Data of Birth (Month, Dey, Yeer) March 23, 7. Age (In yrs. last birthdey) Birthpleca (Stata or Foreign Country) Deys 1□ M 25 F 168-22-3723 72 Yrs. 1926 Řankin, PA Usuel Rasidenca of Decadent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits P.G. 1 Yes 2 No Forestville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2505 Oak Glen Way 20747 United States Was Decadant Evar in U,S. Armed Forces? 11. Marital Stetus Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. 1 Nevar Marriad 2 Married 1 ☐ Yas → No If Yes, Give \( \text{A} \) Yaar or Detes: 1 ☐ Yes 2 ☒ No Specify: 3 ₩ Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Frank Cirbus Susan Kocik 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Susan Vanhorenbeck (DAUGHTER) 2505 Oak Glen Way, Forestville, Maryland 20747 20a. Method of Disposition 20b. Plece of Disposition (Nema of cematary, cremetory or other plece) Dec 22, P998 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State Braddock Catholic Cemetery Braddock Hills, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, '6633 Old 21. Signeture of Furneral Sarvice Licensea Alexandria Ferry Road Clinton Maryland 20725

**Physician** /Medical Examine

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

8

**Funeral** 

Director

or items 23a control

permit. Pages 1 and 2 should be filed within 72 hours efter death. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event. In

Baltimore, Maryland 21215-0020

the Marylend la or 28a-f show

been signed by the a should be detached if To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760,

				waa, CIIIICOII, Ma	tryiana 20733
3a. Port1. En or the disease, or complete his, a heert failure. List only o	icetions that eaused the das na cause on each line.	ath. Do not enter the mo	ode of dylng, such as cardi	ec or respiratory arrest,	Approximete Intervel Between Onset and Deeth
Immediate Ceuse (Final disease or condition resulting In death)	. Color	Cance.			3 years
resulting in death)	Due to	(or as a consequence of	):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dos to (	on as a consequence of	).		
cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (	or as a consequence of	):		
Pert II. Other algnificant conditions con	stributing to death but not re	sulting In tha underlying	causa givan In Pert I.	23b. Did tobacco use co	entribute to the cause of death?
				24e. Wes en autopsy performed?	24b. Wera sutopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 KNo	1 ☐ Yes 2 ☐ No
25. Wes casa referred to medical examiner?			26. Place of De	seth (Check only one)	
1 Yes 2⊠ No	lospital: 1   Inpatient 2	☐ ER/Outpetient 3☐ D	OA Other: 4 Nursing	Homa 5⊠ Rasidenca 6 □Oth	ner (Specify)
27. Menner of Deeth  1	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	
3 Sulcide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	noma, farm, street, fecto	ry, offica	28f. Location (Street and Numb City or Town, Steta)	ber or Rural Route Number,
29a. Certifler (Check only one) SCartifying Physical Examination (Check only one)	ilcian: To the best of my known: On the basis of axamino and freenar stated.	owledge, deeth occurred etlon end/or investigetion	d et the time, dete end placen, in my opinion, deeth occ	ee, and due to the ceuse(s) end me curred et the tima, date and pleca,	enner es stated. end due to the cause(s)
29b. Signature and titla of certifier	el		D 0023600	11	d (Month, Day, Year)

D 0023600

Bruce R. Kressel, M.D. 2141 K. Street, N.W. Suite 707, Washington DC 20037

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signetura

31. Dete filed (Month, Day, Year)

# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Tima of Deeth

20:26

10d. Inside City Limits

Approximate Intervei Between Onset and Deeth

ICak

23b. Dfd tobacco use contribute to the cause of death?

Dec 28, 1998

1eals

1 XYes 2 No

Amend #1, McMillan, 12/30/98, drw 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 19989ar Dec **Physician** 27 VIRGINIA MC-WHILLTAN McMillan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Howard County General Hospital If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey. Year)
April 12,1936

8. Birthplace (State or Foreign Country)
Washington, DC 5. Social Security Number 7. Age (In yrs. last birthdey) 62 Yrs **Funeral** Months Hours 1□M 2X F 220-42-2652 Director Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location worke ! r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at Director Atlanta Georgia 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 30313 430 Techwood Drive NW #C803 death 1 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or the any injury or other traumatic avent, the Medical Exercises 1 Never Merried 2 Married Specify: Black 1 ☐ Yes 2XXNo Specify: altimore, Maryland 21215-0020 py 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone else's home Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Brogden America Leroy 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 1516 Cox Road Huntingtown, MD 20639 Paulette Creek/Daughter 20b. Piece of Disposition (Name of camatary, cramatory or other plece) 20a. Method of Disposition Date 20c Location - City or Town, State 1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removei from State 1/2/99 Chesapeake Beach, MD Ernestine Jones Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licenses lacly a. Swell 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errast, shock, or heart failure. List only one cause on each lina. **Physician** /Medicai Immediata Cause (Final Cardiovasaular disease or condition resulting in deeth) Examiner Examiner MSIDH The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last and Records, P.O. Box 68760, the Due to (or es e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and addrass of person who completed cause of death (item 23a) (Type, Print)

80 use

attending physician Physician/Medical been signed by the should be detach þ Completed certificata To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be Certification: To funeral

DATRYCE

31. Date filed (Month, Dey, Year)

Medical

					1 ☐ Yes 2 ☐ No	3 □ Probably 4 Unknow						
					24e. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?						
					10 Yes 20 NO	1 ☐ Yes 21 No						
25. Was case refer	red to medical	26. Place of Death (Check only one)										
examiner?	No	Hospital:	2 ER/Outpatient 3	Home 5 Residence 6 Ot	her (Specify)							
27. Maymer of Deet 1 △ Naturel 2 ☐ Accident	h 5 Pending Investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occu	rred						
3 ☐ Sulcide 4 ☐ Homicide	6 Could not b determined		At homa, ferm, street, facecify)	ctory, office	28f. Location (Street and Num City or Town, Steta)	ber or Rural Route Number,						
29e. Certifier (Check only one)					ce, end due to the cause(s) and m curred et the time, date end pieca,							
29b. Signature and	titie of certifier		Desta	29c. License number	29d. Date signe	ed (Month, Day, Year)						

rem

State Registrar

completely

4565 Hemlock Cone Way Ellical City MD 21042 A-TOYE, MD 32. Registra/s Signatura DEC 3 0

Division of Vital

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Date of Death 6:00AM John Edward Morrow, Jr. 25, 1998 4c. County of Death Dec 4a Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death 6805 Farragut Street Hyattsville Prince George 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) 15M 20 F Months Days Hours Min North Carolina Yrs. 577 05 9253 80 Aug 25, 1918 10b. County 10c. City. Town or Location 10d. insida City Limits 1 Yas 2 No Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6805 Farragut Street 20784 14. Hace - American Indian, 12. Was Decedant Ever In U.S. Armed Forces? XXYas 2 No 1942 If Yes, Give Yaar or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager Peoples Drug Store 18. Mother's Name (First, Middle, Malden Surnama) 17. Father's Name (First, Middle, Last) John Edward Marrow, Sr. Trinnie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katharine Morrow (WIFE) 6805 Farragut Street, Hyattsville, Maryland 20784 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXurial 2 Cramation 3 Ramoval from Stata Cedar Hill Cemetery Dec 29, 1998 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signatura de Ineral Sevice Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Finel mfinitu disaasa or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

Directo

Funeral

by

Completed

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Examiner

**Funeral** 

Director

the Maryland

pernit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show early Injury or other treumstic event, the Maries in the Injury or other treumstic event, the Maries is an injury or other treumstic event, the Maries is an injury or other treumstic event, the Maries is an injury or other treumstic event, the Maries is an injury or other treumstic event, the Maries is an injury or other treumstic event, the Maries is an injury or other treumstice.

Baltimore.

Examiner pue physician of the burial Physician/Medicai 98

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Certification:

Medical

completely

within 2

27. Manner of Deeth

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and the of certifian

31. Dete filed (Month, Day, Year)
DEC 3

3 Suicida

29a. Cartifian

5 Pending

ettending ed by the e signed by t Completed by should been : hes

requires that the deeth certificate be executed Box 68760. 0 ۵ Records, The law certificate Division of Vital Mospital or Attending Physician: '24 hours efter death.
 Funeral Director: After this certifies director funeral the filled in by

10+1

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death | Check on v one 1 Yes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. tnjury at Work?

28a. Date of Injury (Month, Day Year)

invastigation 6 Could not be determined

28b. Time of tniury

28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 22 No

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home Residence 6 Other (Specify) 28d. Describe how Injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licensa numbe 29d. Date signed (Month, Day, Year)

1 Yas

2 No

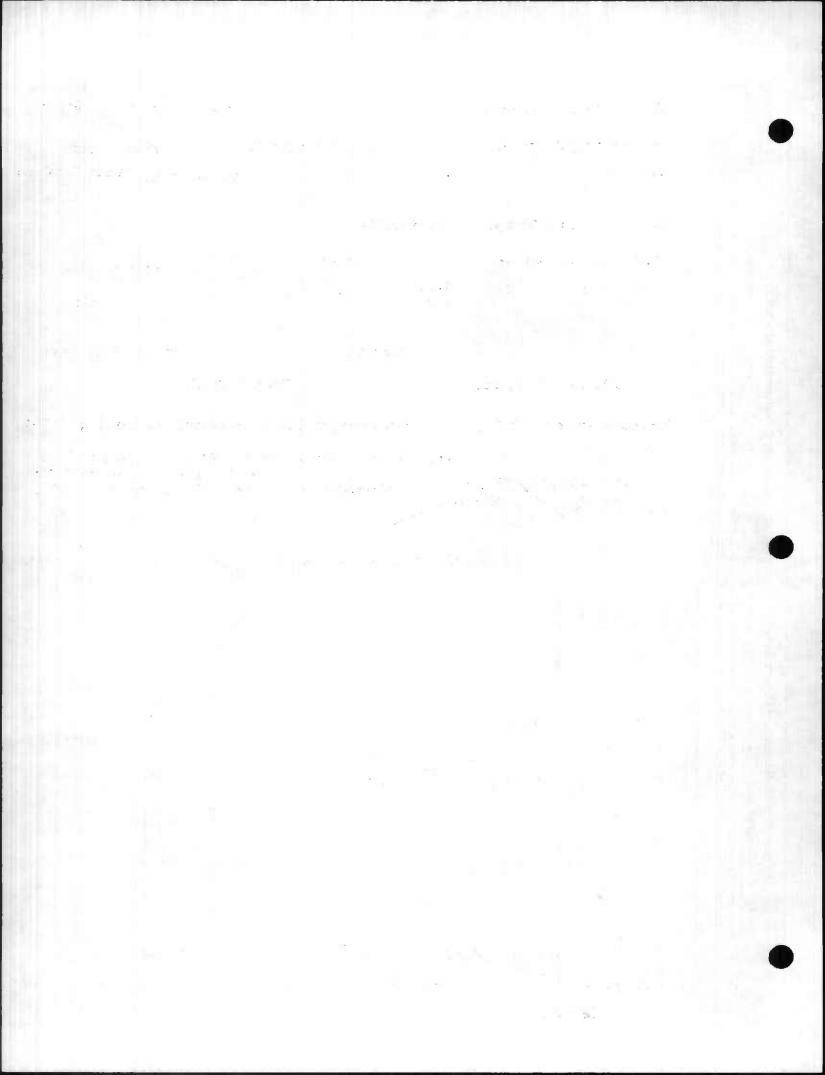
Anne 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

du cody MEND

1998

32. Registra/s Signature

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** Mayhew Sue Brown Dec 17, 1998 12:45 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth **Examiner** Capital Heights Prince George's 4613 Omaha Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (in yrs. last birthdey) Birthpleca (Stata or Foreign Country) **Funeral** 1□ M 200 F Months Yrs. 579-07-2332 85 1913 Virginia **Director** March 2, Usual Residence of Decedent with the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits rail, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yas 200No MD Prince George's Capital Heights Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4613 Omaha Street 20743 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status be filed within 72 hours after de titel Hygiene.
d other than "natural", or item event, the Med cal Express. Black, Whita, etc. 1 ☐ Yes 2 ☐ No tt Yas, Give X Year or Dates: 1 Nevar Married 2 → Married 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry 16a, Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) Jelleffs Elementary/Secondary (0-12) College (1-4or 5+) Department Store 12 Clothing Buyer permit. Pages 1 and 2 should be filed.
Depertment of Health and Mentel Hygu Important: If them 27 is marked other any Injury or other treument. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Tensie Glenn Pickeral Pickeral Ali 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Capital Heights, MD Husband 4613 Omaha Street, Isaac Mayhew 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method ot Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cremation 3 Ramoval from State 12/19/98 Gretna, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) Mayhew Family Cemetery 21. Signature of Funeral Service License 22. Nama and Address of Facility Lee Funeral Home Inc. a 6633 Old Alexander Ferry Rd. , Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart tailure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) Wedina (ENSSMIASON)an nos Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence ot): for use es signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 462 Unknown þ 24b. Were autopsy tindings available prior to completion of causa of deeth? been si 24e. Wes an eutopsy performed? Completed is certificate has by director, page 2 s 1 ☐ Yas 2 No 1 Yas 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was cese reterred to medicel examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 VNo Other: 4 Nursing Homa Residence 6 Other (Specify) 10 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1-ENatural 5 Pending 1 Yes 2 No Invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 Homleide C To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 dertifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) end manner as stated.
2 death occurred et the time, date end place, and due to the cause(s) 29a. Certifier edicai and manner stated. 29c. Licansa number 29b. Signatura and title of certifier 29d. Data signed (Month, Day, Year) ess of person who completed ceuse of death (Item, 23e) (Type, Print)

11701

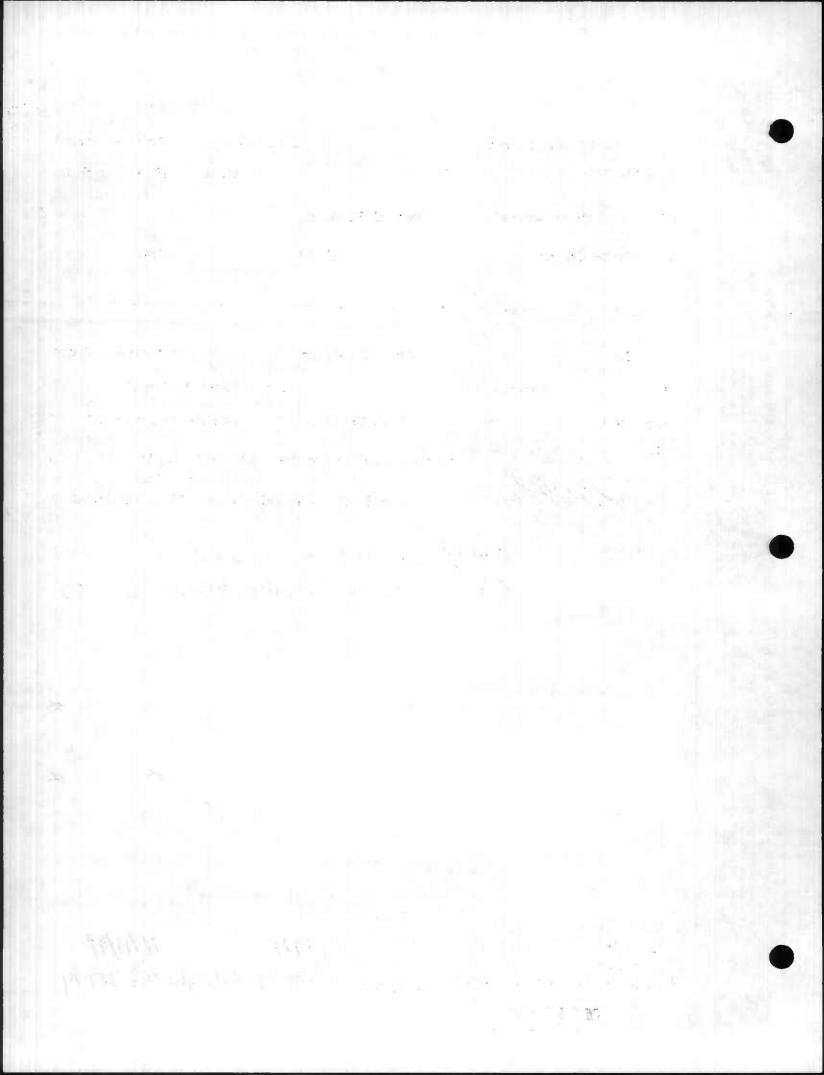
32. Registray's Signeture

Washington MI

Frank M. Pypa M. D. 31. Date tilled (Month, Dey, Year)

DEC 3

12 State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Dete of Death 3. Time of Death Month Vaa MORELAND DECEMBER 21, 1998 04:10 4b. City, Town, or Location of Deeth 4c. County of Death Calvert Prince Frederick

Examiner **Funeral** 

**Physician** 

/Medical

Director

Director

Funeral

þ

Completed

the Maryland 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at filed within 72 hours after of Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 is marked other any injury or other traumatic event, pages.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examines

Examiner

Physician/Medicai

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Completed

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Certification:

edical

ettending physician and for use as the burial-transit The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, as the signed by t peed has certificate or Attending Physician: after death. this funeral After t in 24 hours after which the Funeral Director: After whiled in by the funeral filled in by the funeral funeral

1. Decedent's Neme (First, Middle, Last) FREDTA 4e Facility Neme (If not institution, give street and number) Calvert Memorial Hospital If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys 1□M 21 F 578 72 0256 61 June 5, 1937 West Virginia Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Calvert Barstow 10e. Street and Number 10f. Zlp Code 10a. Citizen of Whet Country? 20610 USA 90 Barstow Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: white 3₺ Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) 8 homemaker own home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Myrtle Jane Persinger Everett Randolph Boone 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Jane A. Persinger / daughter P.O. Box 69, Barstow, MD 20610 20b. Piece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 X Remove from State 12-26-98 4 ☐ Donetion 5 ☐ Other (Specify) Elk Knob Cemetery Judson, WV 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Rausch Funeral Home, P.A., Owings, MD 20736 12033 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth ACUTE RESPIRATORY FAILURE

Due to (or es e consequenca of): Immediete Ceuse (Final diseese or condition resulting in deeth) Due to (or es e consequenca of):

CONGESTIVE HEART FAILURE

Due to (or es e consequence of): Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In death) Lest PULMONALE OR Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 lae 2 No

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

24a. Wes an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

2 N.H

26. Place of Deeth (Check only one)

1 ☐ Yes 2 VIIIo

25. Wes cese referred to medicel exeminer? 1 Yes 2 No

5 Pending

Investigation

6 Could not be determined

27. Menner - Leath 1 Junturel

2 ☐ Accident

4 Homicide

(Check only

3 ☐ Sulcide

29a, Certifier

28e. Dete of Injury (Month, Dey Year)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Roufe Number, City or Town, Stete)

29b. Signeture and title of certifier

29c. License number -025519 29d. Date signed (Month, Dey, Year) 12-21-98

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Atul R. Shah, M.D. Prince Frederick, MD 20678

State

32. Registrar's Signeture

Dacker

1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner steted.

Registrar

within 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** JEAN INGELO MOORE 850 AM 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNADOLIS SUNRISE ASSISTED LIVING CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** Days 213 36 0777 1 M 2000 82 Months Hours Director Usual Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 ☐ Yes 2 € No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road 21401 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [Ž]No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Merital Stetus 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Own Home 4 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Neme (First, Middle, Last) Carl Irwin Martha Williams 19a, Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Moore (son) 3203 Breckenridge Way/Riva Md 21140 20b. Place of Disposition (Name of cemetery, cremetery or other place)
Metropolitan Crematory 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burlei 2 🖾 Cremetion 3 ☐ Removel from Stete 12/29/98 Alexandria VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Advent Funeral & Cremation Services Annapolis MD 21401 23a. Pert1. Enter the disease, or complications that mused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause to sech line. Approximate Interval Between Onset and Death immediate Causa (Finel disease or condition resulting in death) Longestive Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury pertension Years Physician/Medical that initieted events resulting in death) Last Due to (or es a consequence of): Pert Ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed?

**Physician** /Medical Examiner

tem 27 is marked other than "natural", or hema 25a or 28a-f show other traumatic event, the Medical Examinar must be notified at

filed within 72 hours after Hygiene. ther than "natural", or its

permit. Pages 1 and 2 should be filed Department of Heelth and Mantai Hygii Important: If Item 27 is marked other any Injury or other treumatic event. It

Baitimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records.

the

State

Registrar

**DHMH 16 Ray 6/95** 

physician and the buriel-transit death certificate be executed 80 has 92 or Attending Physician: after death. this After ti Director: / To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by edical

Completed Be 9 Certification:

2 Accident

3 ☐ Sulcide

(Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Matural

5 Pending investigation 6 Could not be 4 ☐ Homicide

28a. Dete of Injury (Month, Dey Year) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

00

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Mother (Specify) A 51 + c 28d. Describe how injury occurred Living

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

TO Yes 20 No

29b. Signature and title of certifier

D 25499

28c. Injury at Work?

ritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

unu and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

180 JAmes

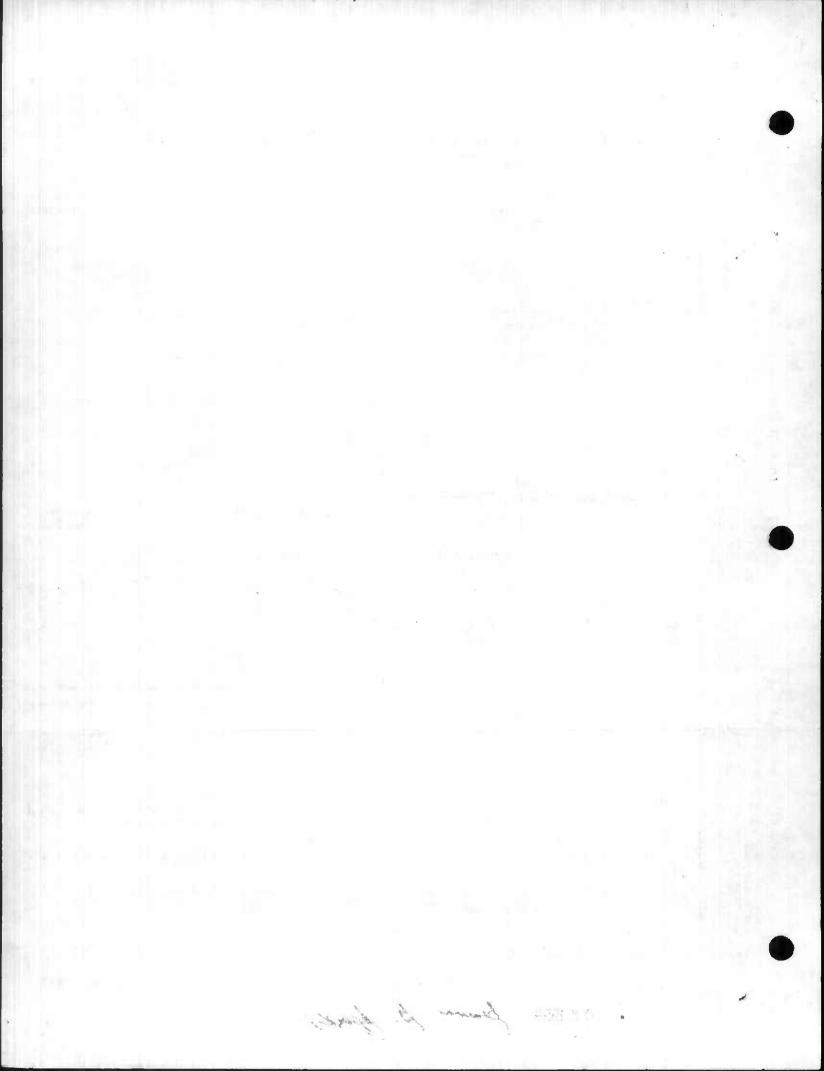
32. Registrer's Signature

31. Date filed (Month, Dey, Year) JAN 0 8 1999

**ORIGINAL** 

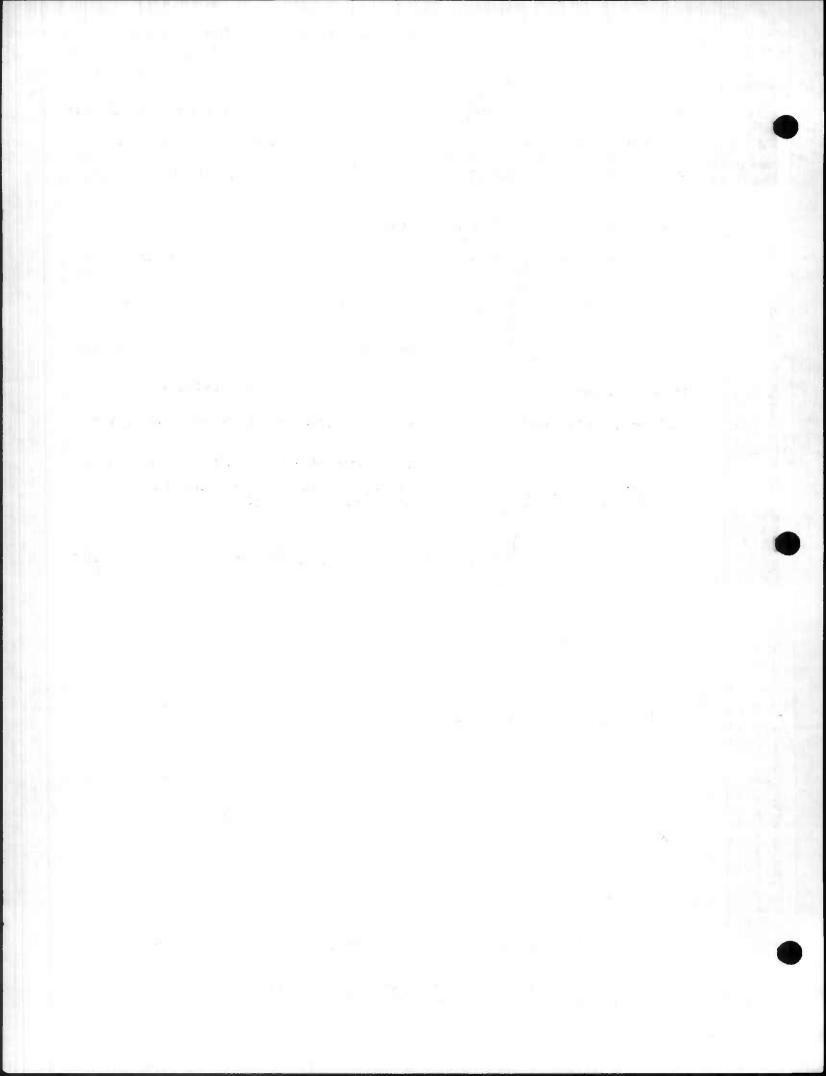
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1 TYes 2 No



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cen	tificate of	f Death	R	eg. No. 9 8	L	1040	
	Physici	00	Decedent's Nama (First, Middle, Last	)	10				2. Dale of Dea Month	th Day	Year	3. Time of De	eath
	/Medi		Margaret Gallagher	r Pei	x					er 29 1		4:00 a	ım
	Examir	ner	4a. Facility Name (If not Institution, giva	and the second second				4b. City, Town, or	Location of Death	4c. County of	of Death		
			12115 Greensboro 1				# Hadar 4 Ma	Greensbo		Carol:			
	Funeral Director		5. Social Security Number 6. Se 072-12-1261  Usual Residence of Decedent	7. Ag	je (In <i>yrs. l</i> as. 2	t birthday) _ Yrs.	Months Day			,1906	9. Birthpl Count COI	laca (Stata or F try) In •	oreign
	show at at	-	10a. State 10b. County		10c. City, T	Town or Loc	ation				10	0d. Inside City I	
	The N	Director	Md. Caroline 10e. Street and Number		Green	sboro	1 404 771 0 4			20.00		446	140
	A D A	D		0.1	,		10f. Zip Code		1	0g. Citizen of W		try?	
	Jeath Tre 23	Funeral	12115 Greensboro I	12. Was Decedent I	Ever in U.S.	13. W	21639	Hispanic Origin? (5	Specify Yas or No-	U.S.A.	Amarica	an Indian.	
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Hems 23a or 28a-f show but, the Medical Examiner must be notified at	by	1 Nevar Married 2 Married 3 Microsoft Married 4 Divorced	Armed Forcas?  1  Yes 2 1  If Yes, Give Year or Dates:			Yas, specify Cu □ Yes 2 1 No	Hispanic Origin? (5 ban, Mexican, Puar Specify:	to Rican, etc.)	Black	White, e	etc.	
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d 2	filed within Hygiene.		12 17. Fathar's Name (First, Middla, Last)	2		Teac	.1161	19 Mothode No	me (First, Middle, I				
Maryland	A D D S	o Be							Bell Gal:		l)		
ary		To	Thomas Gallagher  19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailing	Address (Street	et and Number or R			Stete. Zip	Code)	
	2472		Richard T. Peix (s	on)				boro Rd.					
ore,	of Healt of Healt Item 2		20a. Method of Disposition		20b. Plac	e of Dispos	ition (Name of atory or other pi	aca)	Date	20c. Location - (	Dity or To	wn, Stata	
E	Peges nent of h int: If ite iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					tion Ctr	.12-29-98	Chest	er M	d.	
Baltimore,	permit. Peges Department of Important: If It any Injury or o		21. Signatura of Funeral Sarvice Licens	00	-	22	Name and Add	ress of Facility					
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			23a. Part1. Enter the disease, or compleshock, or heart fellure. List only or	ications that caused ne cause on each lir	tha death. I	Do not entai	tha mode of dy	ring, such as cardia	c or respiratory arm	est,		Approximate interval Between	en
	Physician			- 1-	1 .		,					Onset and Dea	ath
1	/Medical Examiner		Immediate Cause (Final disaasa or condition resulting In death)	. Meta	STOUT	G	CO 101	) can	er			years	
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	uted 1 ansit	Examiner		0. ———	5		1 0				<u> </u>		
ć	the death certificate be axecuted by the attending physician and sched for use as the burtal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury		Due to (or as	s a consequ	ence of):				- 1		
68760,	te be ysicia ne bui	Medical	that infleted events	<b>3</b>	Due to (or as	a consequ	ence of):						
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-	the a	Physician/	Part II. Other significant conditions con			ng in the und	tertying cause g	iven in Pert I.	23b. Did to	bacco uea con	tribute to	the cause of c	death?
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io	Attending F r death. octor: After by the funer	atlo	1 ► Naturel 5 □ Pending investigation	(Month, Da)	( rear)	Injury		Yes 2 No					
Division	of or Attence effector: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home c. (Specify)	, farm, stree	et, factory, office		28f. Location (St City or Town		r or Rural	Route Number	7.
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physical Carl Examination (Check only one)	elclan: To the best of ner: On the basis of end manner sta	examination	dge, death of and/or inve	occurred at the testigetion, in my	time, date and place opinion, death occ	a, and due to the courred at the time, do	ause(s) and man ate and place, a	iner as str nd due to	ated. the cause(s)	
	Within To the Comp	X	29b. Signatura and titla of certifiar	- 100		4.5	29c. Licer	nse number	2	9d. Date signed	(Month, L	Day, Year)	
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			30. Neme and address of person who co				rint)						-
			W. Zaki, MD 920				nton, N	D 21629					
	Sta	te	31. Date filed (Month Day Year) 0 19	98 32. Registra	r's Signaldre	Ø.	spar	Ks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Yaar 3:15 AM RICHARD CARL RAUSCH 1998 DECEMBER 20 4e. Facitity Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY CENTER: GENESIS ELDERCARE SALISBURY WICOMICO 5. Social Sacurity Number If Under 1 Yaar | If Undar 24 Hrs. Birthpleca (Stata or Foreign Country) 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) 1⊠M 2□F Months 216 18 5172 82 Oct 28, 1916 Annapolis, MD Usuet Residance of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Parsonsburg 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9017 Whiteville Road 21849 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian, Biack, White, etc. 1 X Yas 2 □ No If Yes, Give 1942–45 Year or Datas! 1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highast grade completed) Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Etementary/Secondery (0-12) Coilege (1-4or 5+) Test mechanic Federal Government 11 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnema) Martin William Rausch Mabel Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Allen L. Rausch / son same as # 10 above 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crametory or other place) Date 20c. Locetion - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12-24-98 Alexandria, VA 21. Signature of Funaral Sarvice Licensee 22, Nama and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Entar the disease, or complications that laused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart feilure. List only one ceuse op each line. Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in deeth) 5 days Mumonto Due to (dr es a consequence of): Sequentially list conditions, if any, leading to Immadiate cause. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? wosepres 1 ☐ Yes 2 ☐ No 25. Was case referred to medicet 28. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 8 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

Box 68760. Records. P.O. peed certificate Division of Vital or Attending Physician: after death. After Director:

Examiner Physician/Medicai þ Completed Be Certification: To

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(Check only one)

29a. Certifier

**Physician** 

/Medicai

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**Funeral** 

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permit. Pages 1 Department of H Important: If ited any Injury or oth

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Examiner

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Baltimore, Maryland 21215-0020

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• Funeral DI the Hospital

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State Registrar

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the causa(s) and manner as steted.

Madical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred et the time, date end piece, and dua to the cause(s) and menner stated. lmids

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29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) WENRICH KODNE

100 POWER ST. SALISBURY

31. Dete filed (Month, Day, Y. 32. Registreds Signature 1998

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death December 25, Year 1998 9:30am **Physician** RUDOLF REICHEL /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert 4180 Dunn Road Huntingtown if Under 1 Yeer | if Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. iest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□F Months Deys Hours Min Yrs. 219 34 9816 86 Director June 12, 1912 Czechoslovakia Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Examinat must be notified at Huntingtown 1 Tyes 2 N No Maryland Calvert Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4180 Dunn Road 20639 Germany Funeral death 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 2 should be filled within 72 hours after nand Mental Hyglene. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Farmer Agriculture 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) August Reichel Hedwig Benischke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra G. Marianne Terrell P.O. Box 1132, Prince Frederick, MD 20678 20b. Plece of Disposition (Name of cametery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Gardens 12/28/98 Dunkirk, MD 22. Neme end Address of Fecility 21. Signeture of Funerei Service Licenses Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, P.O.Box 100, Owings, MD Eleves F 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete interval Between Onaet and Deeth **Physician** Ischemit Myocardropathy

Due to (or es e consequence ot):

Frento-s clerritic Cardrovaseulan Disease Immediete Cause (Finei diseese or condition resulting in death) /Medical Examiner Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. Physician/Medical thet initiated events resulting in death) Last Due to (or es e consequence of): USe Pot P.O. ed by the a detached i Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contributs to the cause of death? Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings Completed 24e. Wes en eutopsy neumono available prior to completion of cause of death? has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 NAesidence 6 Other (Specify) 10 this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 27. Menner of Deeth Certification: 28d. Describe how injury occurred Neturel Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 100 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuae(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Cernes MD D 17245 December 26, 1998 12 30. Name end eddress of person who completed cause of death (item 23a) (Type, Print) Gerald P. Sterner, M.D., P.O. Box 929, 19 Cesapeake Beach Rd. E., Owings, MD, 20736 31. Dete filed (Month, Day, Year) 32. Registreds Signeture State Denero. DEC 2 8 1998

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Registrar

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25. Was case referred to medical

1 FT Yes 26. Place of Death (Check only one) 1 Yes 2 No

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 17 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? A Found: 46 1 Neturel 5 Pending Found: 7-98 1 ☐ Yes 2 No Investigation UNKNOWN 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plecs of Injury - At home, ferm, street, tectory, office building, etc. (Specify)
FOUND AT HOME Location (Street and Number or Rural Route Number, City or Town, State) 7 0 3 5 KENT RD., 4 Homicide

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled.

SUNERLAND, MH

2 □ No

DECEMBER 28,1998

29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

and andress of person who completed cause of death (Item 23a) (Type, Print) 30. Neme es

111 Penn Street, Baltimore, Maryland 21201

State Registrar

ner 32. Registrar's Signeture Jener

O.C.M.E.

certificate

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

edical Certification:

Division of Vital

TOT. and in -----11.

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 1998 7:30AM 27 1998 4c. County of Death Margaret Elizabeth Smith Dec 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number Bradford Oaks Nursing Home If Under 24 Mis. B. Date of Birth (Month, Dey, Year) Prince George 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1□ M 2 KF Months Deys 76 Yrs. 213-38-3762 October 10,1922 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 190 Boones Drive 20711 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XXo If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2XXVo Specify: Specify: White 3XWidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th N/A Waitress Restaurant 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) James Sanders King Pearla King 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Rouser (Daughter) 190 Boones Drive Lothian Maryland 20711 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dec. 31,1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurlel 2 Cremetion 3 Removel from Stete St. Mary's Catholic Church 4 □ Donetion 5 □ Other (Specify) Piscataway, Maryland 21. Signature of Fun I Service 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 is thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, ause on each line. Part1. Enter the diseese, or complic shock, or heert feilure. List only Interval Between Onset end Deeth Immediete Ceuse (Final diseese or condition resulting In deeth) Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? t CT You 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

Examiner

Physician/Medical

Be Completed by

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Certification:

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31. Dete filed (Month, Day, Year)

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**Physician** 

/Medical

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**Funeral** 

Director

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n end Mental Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyralimportant: if item 27 is metally injury or other.

Directo

Funeral

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filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020

physicien and s the burial-transit attending p signed by the a should

The law requires that the death certificete be executed After this certificate has funeral director, page 2 Hospital or Attending Physician: To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: At completely filled in by the fu death.

Division of Vital Records, P.O. Box 68760

State Registrar

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1. Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

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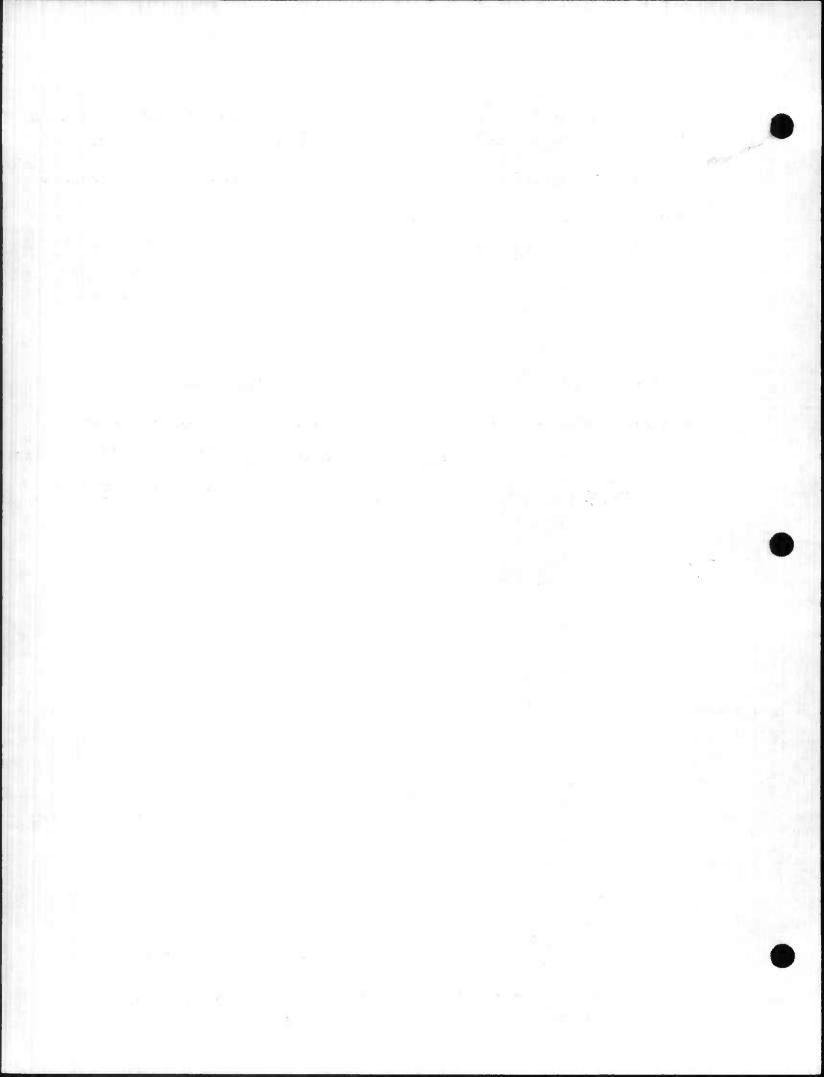
Louis Kaufman, M.D.

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3 Time of Death Dec 22, 1998 **Physician** CARL 1:00PM /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not Institution, give street end number) 4c. County of Death **Examiner** 6309 Goldenrod Court Upper Marlboro Prince George's If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Min. 1₩ 2□F 67 Yrs 185 24-2400 Director Reading , PA Feb 8, 1931 Usuel Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yas 2 No Upper Marlboro Director MD P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with in Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23s or any injury or other traumatic event, the Medical Examiner must be nownly injury or other traumatic event, the Medical Examiner must be nownly injury or other traumatic event, the Medical Examiner must be nownly injury or other traumatic event. 20772 6309 Goldenrod Court United States Funeral 14. Race - Amarican Indian Black, White, etc. 12. Was Decedani Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) MXYas 2□No 1948 If Yes, Give Yaar or Datas: 1951 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 25 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade completed) 16b. Kind of Businass/industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Federal Government 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Emma Jefferson Tiley Wenger 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Tiley (WIFE) 6309 Goldenrod Court, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, cremetory or other place) Lee Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland December 23, 1998 21. Signature of Lice see 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Part1. Enter the cisease, or cripolications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Zyeass /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner that the death certificate be executed physician and s the burial-trens Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) 80 use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown A 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No certificate I or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner?

1 Yes 2 Ho Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 4 sidence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA Juneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 1 (Chlatoral 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 24 hours a Funeral D Medical 29a. Certifier 1 Gestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the

841

State Registrar

31. Data filed (Month, Day, Year)

29b. Signature and title of certifier

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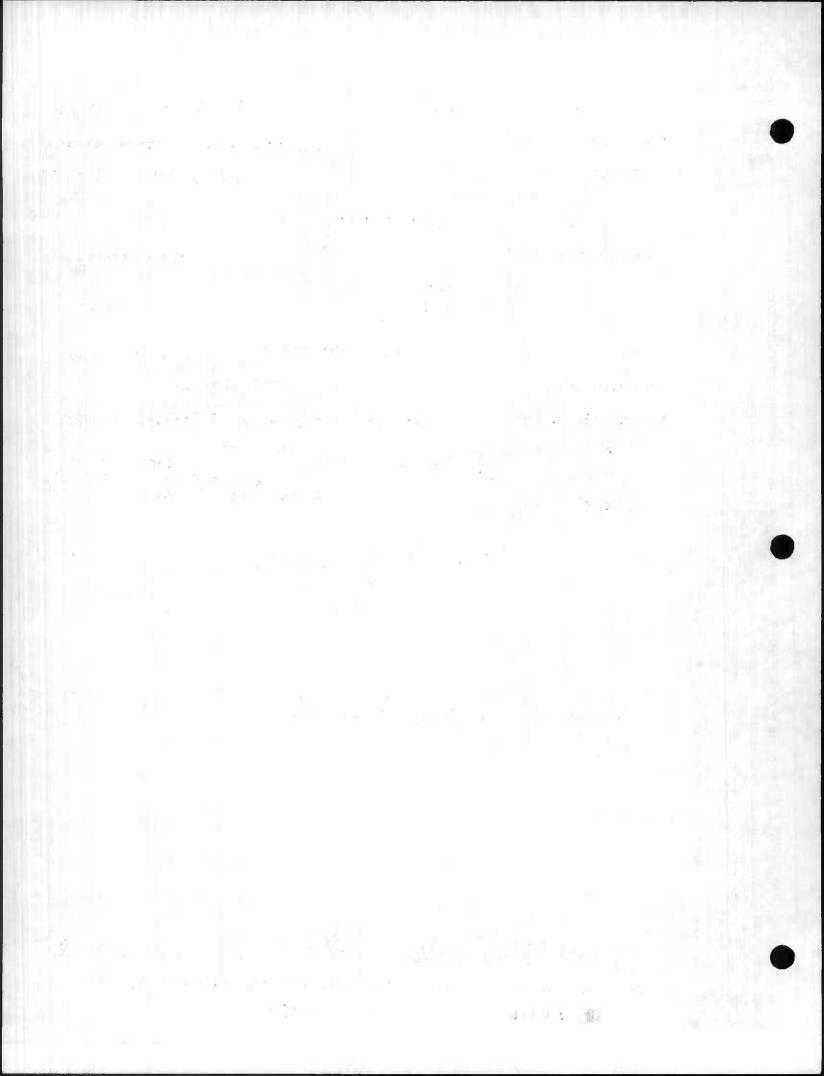
30. Name and address of person who con 7700 Old Branch Ave, B-102, Clinton, Maryland 20735 Sam Tellawi, M.D. 32. Registrar's Signatura

1998

fitem 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Examine												
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th th	10e. Street and I	Number			107 H	10f. Zip Code	CHILL		10g. Citizen o	f What Cou	intry?	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or forms 23s or 28s-f above any injury or other traumatic avent, his Medical Examination must be notified at once.	3 ☐ Widowed	erried 2 Merried d 4 Divorced	1 Tes 2 If Yes, Give Yeer or Del	No No		□Yes 2ŪŴNo					y:Black	
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vermit. Pages 1 ar Department of Heal mportant: If fram 2 nny Injury or other MGB.		Disposition 2 Cremation 3 [ n 5 Other (Speci		ate	race of Dispos cemetery, crem orest	ition <i>(Name of</i> atory or other pl Hills	*	Date 12/26/9	20c. Location			
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To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After completely filled in by the funeral

Joka

31. Deta filed (Month, Day)

29b. Signeture end title of certifier

DECEMBER 15, 1998

Street, Rt 295 + Western Ave Prince Georges Co, Mcl.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the bases of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled. 29c. License number 29d. Dete signed (Month, Day, Year)

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print)

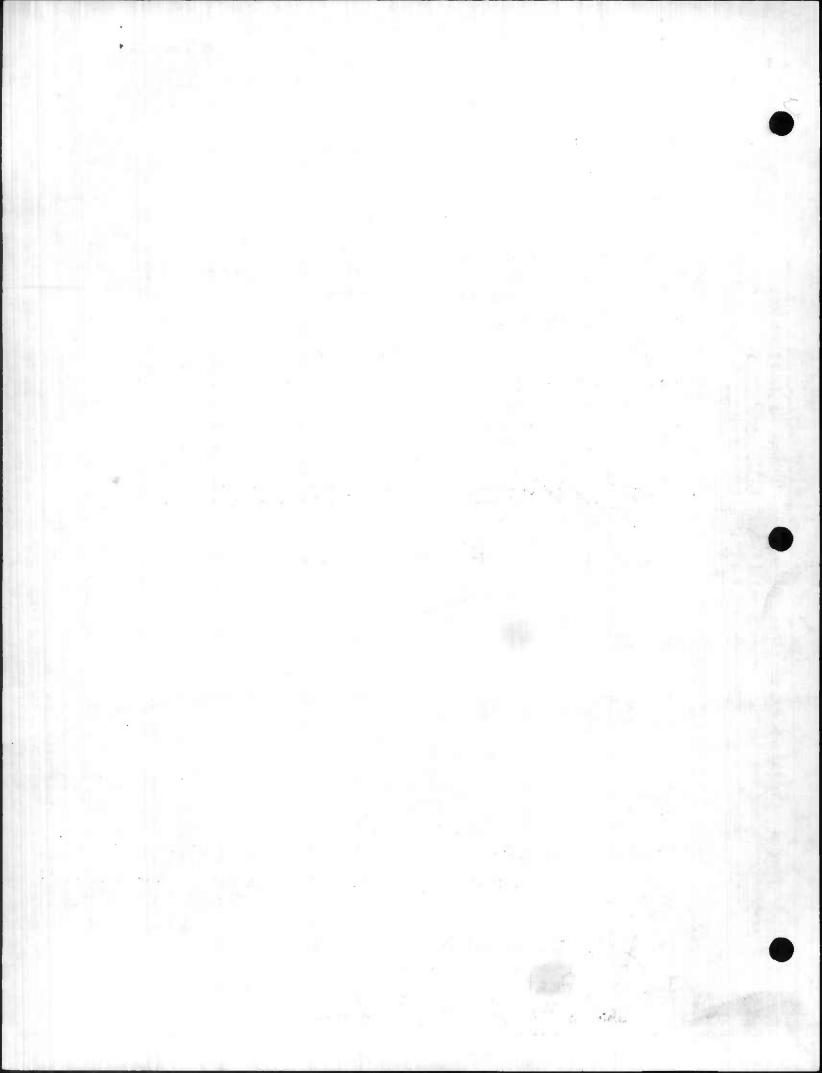
Tane ( 111 Penn Street, Baltimore, Maryland 21201

OCME

State Registrar

1999

32. Rigistrer's Signatura



**Physician** /Medical Examiner **Funeral** WYatt Director Maryland the Д with 7 is marked other than "naturel", or items 23a or traumatic event, the Medical Examiner must be Reese death filed within 72 hours after Baltimore, Maryland 21215-0020 Hygiene. . Pages 1 end 2 should be filk ment of Health and Mental Hy tant: If item 27 is marked oth jury or other traumatic event

permit. Page Department of Important: If any Injury or **Physician** /Medical Examiner

physician and sthe bunal-trans the death certificate be execu Division of Vital Records, P.O. Box 68760. 60 USB Por signed by the a page 2 s has Hospital or Attending Physician: funeral director, this After 24 hours after death.

Funerel Director: Al completely filled in by To the within 2

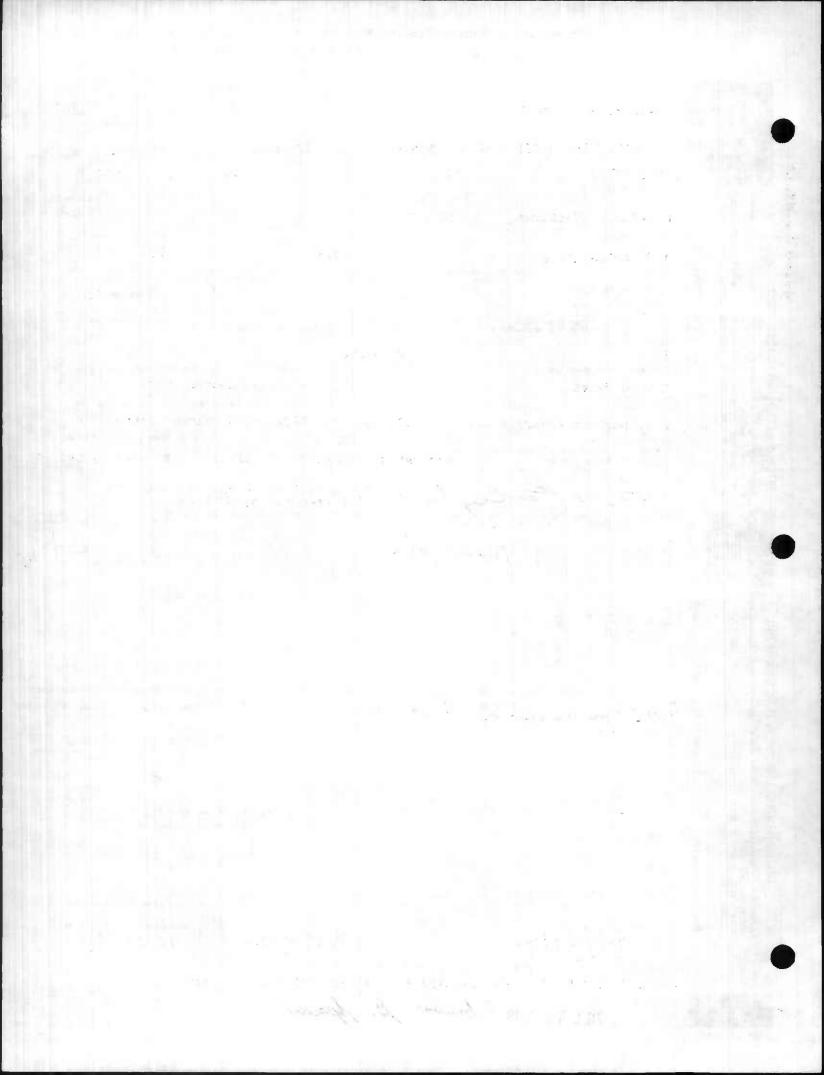
3. Time of Deeth Month DEC 27 1998 Reese Palmer Wyatt 2305 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) MEMORIAL HOSPITAL @ EASTON e (In yrs. last birthdey) EASTON 8. Date of Birth (Month, Day, Yeer) TALBOTT

S. Birthplace (State or Foreign If Under 1 Year 5. Sociel Security Number Months Days Hours Min 15 M 2□ F Aug 27 1934 218-30-1768 Maryland 64 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Maryland Caroline Denton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 IISA 420 Colonial Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled N/A llyrs 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Mattie Hubbard Wyatt Elwood Wyatt 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 21660 P.O. Box 743 Ridgely, Maryland Barbara Evans/ sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burlei 2 ☐ Cremation 3 ☐ Removal from State 12/29 Greensboro, Maryland Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture Juneral Service Licensee Fleegle & Helfenbein Funeral Home, PA Box 160 Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Much me Due to (or as e consequence of): Examiner Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ne 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of death? 1 Yes 2 0 0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of pertifler 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar David H. SMith, MD

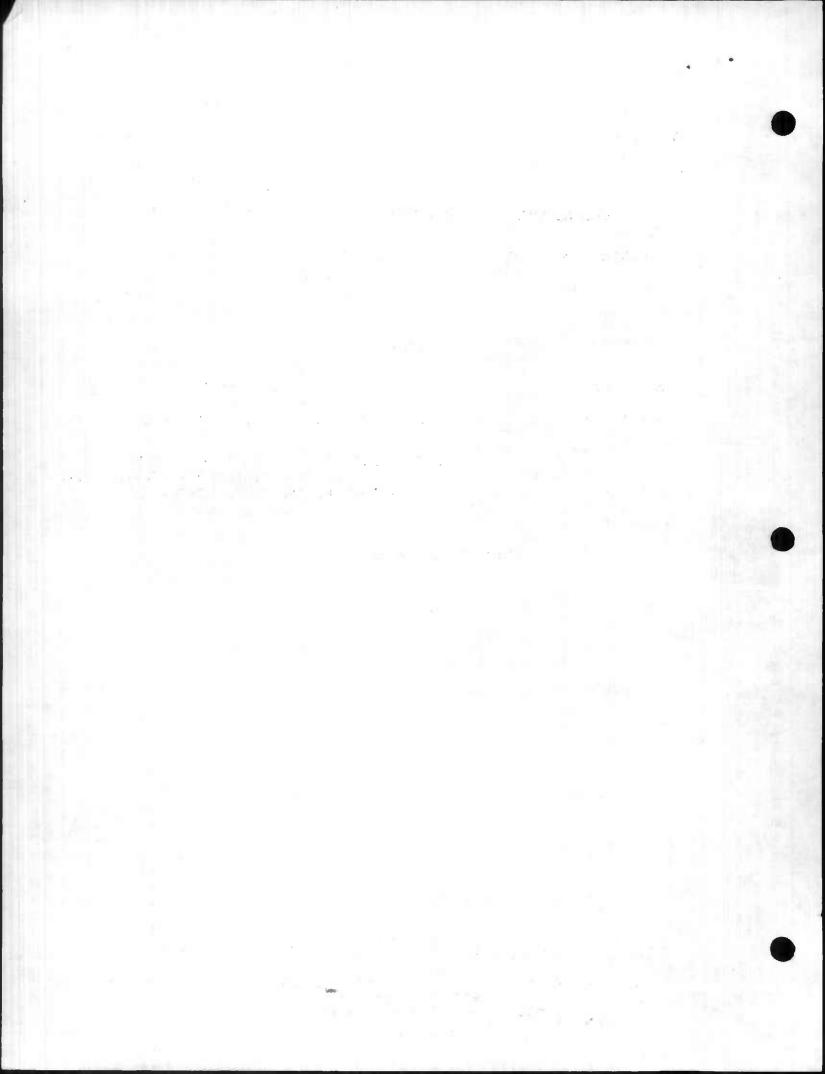
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

21601



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 1 0 4 9

				Ce	rtificat	e or	Death			Rea. No.			
	1. Decedent's Name (First, Middle	e, Last)						1	2. Date of Dec	ath		3. Tim	a of Death
an	LEON MILTON BA	TLEV							Month Decemb	er 17,	1998	5:0	00 P.M.
ai er	la Facility Name (If not institution		mber)		2		4b. City, To	wn, or Lo	cation of Death		y of Death	9.0	7.7
CI	7870 Shirley M	lurphy Cou	irt				Pasac	dena		Anne	Arun	del	
5	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday	) If Under	1 Yeer	If Under 2	24 Hrs.	8. Dale of Birt	h			ate or Foreign
	217-64-5456	1∭M 2□ F	4	5 Yrs.	Months	Deys	Hours	Min.	(Month, Day 12-14-		MD	itry)	ate or Foreign
-	Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or L	ocation						11	Od Ineid	e City Limits
		RUNDEL		ASEDEN									Yes 2 No
5		KONDEL	F.	HOEDEN!									oo zeX
ā	10e. Street and Number				10f. Zip					10g. Citizen of	What Coun	itry?	
Funeral	7870 SHIRLEY M		RT edent Ever in U	16 110		2112		ning /Con	aih Maa as Na	USA	ce - America	no India	
by Fun	11. Marital Status  1 □ Never Merried 2 □ Merr  3 □ Widowed 4 ☑ Divorced	Armed Fo	2 No	3,3.	If Yes, apec		Specify:	, Puerto	cify Yes or No- Rican, etc.)		ck, Whita,	etc.	
3	15. Decedent				dent'a Usue					16b. Kind of B	Business/Inc	dustry	
Completed	(Specify only highes Elementary/Secondary (0-12)	college (		life.	DO NOT us	se retired	during most d)	of worki	ng				
EO	and many documents (0°12)	Conege (	. 401 54)	LONGS	SHOREN	IAN				WATERM	IAN		
Bec	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Nama	(First, Middle,	Meiden Sume	me)		
To B	LEON BAILEY					-11	JES	SSTE	MAE MI	LES			
	19a. Informant's Name/Relations	hip (Type, Print)		19b. Meil	ing Address	(Street			/ Route Numbe		, State, Zio	Code)	
-1	PERCY COX(BROT		W)	1					RANDA				3
1	20a. Method of Disposition			Place of Disp	osition (Nar	ne of		, KD	Date	20c. Location	•		
	t\ Burial 2 ☐ Cremation		State	cemetery, cre	ematory or o	ther plac	ce)	1					
2	4 Donation 5 Other (S)		MT	. ZION			F	1-	-12-99	BALTIM	ORE,	MD	
	21. Signature of Funeral Service	Section	CFSY						LLIPS F				
	Immediate Cause (Final disease or condition resulting in death)	a. Pon	Due to	emorrha for as a conse									
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	S	Due to (	or as a conse	quence of):								
Medica	that initiated events resulting in death) Last	d	Due to (	or as a conse	quence of):						1		
Physician/													
ys/	Part It. Other significant condition	ns contributing to d	eath but not re	sulting In the	underlying c	ause giv	ven in Part I.		23b. Dld 1	obacco use c	ontribute to	the cau	use of death?
Dy Fin									10	Yes 2□ No	3 Prot	bebly	4 Unknown
Completed b			-							an eutopsy med?	ava cor	ailable p	osy findings rior to of cause
E									10%	rea 2□No		XYes	2 No
	25. Was case referred to medical						26 01	of De of			1	a.). 00	
F 0	examiner?  14 Yes 2 No	Hospitel:	lanati	150/0 / 1		Oth	200		(Check only o	11111			
2	27. Manner of Death	28a. Date	No.	ER/Outpatie		)A	4 LI NU	-	forme 5 ØResidence 6 ☐Other 28d. Describe how injury occurred		- ' ' '	y)	
ation	1 Natural 5 ☐ Pending investig	g (Mon pation	th, Day Year)	Injury	м	8c. Injur Wor 1 □	rk? Yes 2□!	- F	Log. Ordertod I	.c. a aquiry cocc			
Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Hornicide determi	ned   286, P1606	of Injury - At hing, etc. (Speci	nome, farm, st	treet, factory	y, office			28f. Location (5 City or Tox		ber or Rura	l Route	Number,
		g Physician: To the Examiner: On the b and man											se(s)
	29b. Signature end title of certified	0			290	. Licens	e number			29d. Dete sign	ed (Month, i	Day, Ye	ar)
<b>≥</b> 2		h ()(	4.0			0							
	Wounte	The you	ll			0.0	C.M.E.			January	07,	1999	
	0. Neme and address of person Margarita Kon		se of death (Ite	m 23a) (Type					Baltim				110



State of

init in Diack indelible lik. Assule All	Copies Ale Legible.	
Maryland / Department of Health and Mo	ental Hygiene 8 4 1 U 5	
Certificate of Death	Reg No.	

If Under 24 Hrs.

Physician	
/Medical	
Examiner	ļ

Bennett Gantt 4a Facility Name (If not institution, give street and number) 413 E. Lafayette Avenue

1. Decedent's Name (First, Middle, Last)

10, December 4b. City, Town, or Location of Death 4c. County of Death Baltimore

3. Time of Death 10:00 P.M.

10d. Inside City Limits

towes 2 □ No

**Funeral** Director

"netural", or items 23a or 28a-f ahow

i filed within 72 hours efter du i Hyglene. other than "natural", or frem

.. Pages 1 and 2 should be filed wittmant of Health and Mentel Hyglen tant: if item 27 is marked other the jury or other treumstic event, the

Department of Important: If eny Injury or page.

**Physician** /Medical

Examiner

sician and burlel-transit

physician s the buriel

for use

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signed by t

should should

pege 2 has

funeral director,

filled in by

completely

certificate

this is

After

death.

ofter death

24 hours e Hospital

within 2 ŝ

or Attending Physician:

The law requires that the death certificete be asscuted

Box 68760,

P.0.

of Vital Records,

Division

Examiner

Physician/Medical

à

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

5. Social Security Number 213-78-4045

Director

Funeral

p

Completed

Be

**Usual Residence of Decedent** 10a. State 10b. County MD NA

10c. City. Town or Location Baltimore

7. Age (In yrs. last birthday) 35 Yrs

8. Date of Birth (Month, Day, Year) Hours 03-24-63

2. Date of Death

Month

Birthplace (State or Foreign Country)
 M D

Black

10e. Street and Number

328 E. LaFayette Avenue 10f. Zip Code 21202

If Under 1 Year

Months

Days

10g. Citizen of What Country?

1998

N/A

USA

11. Marital Status 1K Never Merried 2□ Married

3 Widowed 4 Divorced

MM 2DF

12. Was Decedent Ever in U,S. Armed Forces? 1,☐ Yes 2 ☐ No If Yes, Give Year or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify:

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

various trades

17, Father's Name (First, Middle, Last)

Albert

Johnson

18. Mother's Name (First, Middle, Maiden Sumame) Lillian

Moore

19a. Informant's Name/Relationship (Type, Print)

Lillian Gantt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 328 E. LaFayette Avenue Baltimore, MD.

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery 01-11-99

Laborer

20c. Location - City or Town, Stete Baltimore, MD

21. Signature of Funeral Service Licensee

22. Neme end Address of Facility

On not scaler the mode of dying, such as cardiac or respiratory arrest,

Baltimore, Maryland 21202 1101 E. North Avenue FH

23a. Part1. Enter the disease, or complete was that caused the shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Smoke Inhalation and Thermal Injury

Due to (or as a consequence of):

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

death.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Alcohol and cocaine use

24a. Was an autopsy performed?

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2□ No

Interval Between Onset and Death

25. Was case referred to medical 1 X Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 COther (Specify) SCENE 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 Natural

Accident

4 ☐ Homicide

28a. Dete of Injury (Month, Day Year) 12-10-98 6 Could not be determined

28c. Injury at Work? Foundy: 1 ☐ Yes 2 ☐ No 9:45

Gara e fire

29a. Certifier (Check only one) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) garage

28f. Location (Street and Number or Rural Route Number, City or Town, State) rear of 413 E. Lafayette Ave., Baltimore 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. City, Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s), and manner stated.

29b. Signature as

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) December 11, 1998

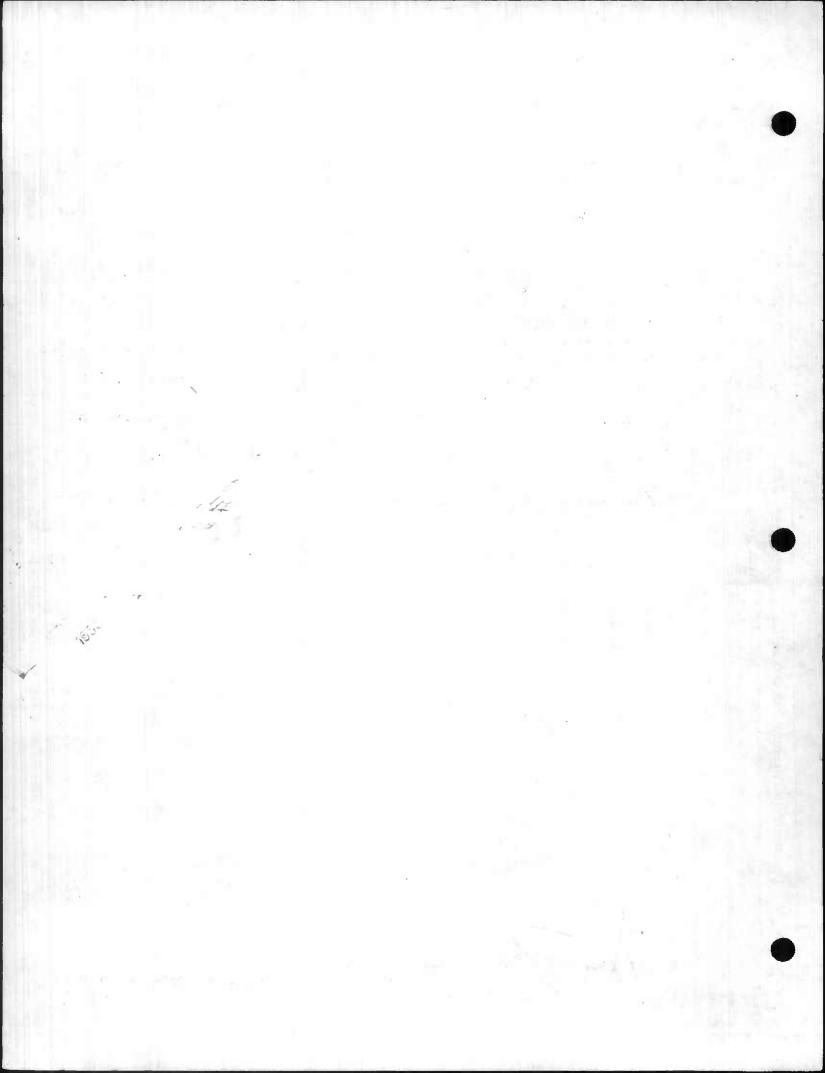
30. Name and addr

use of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

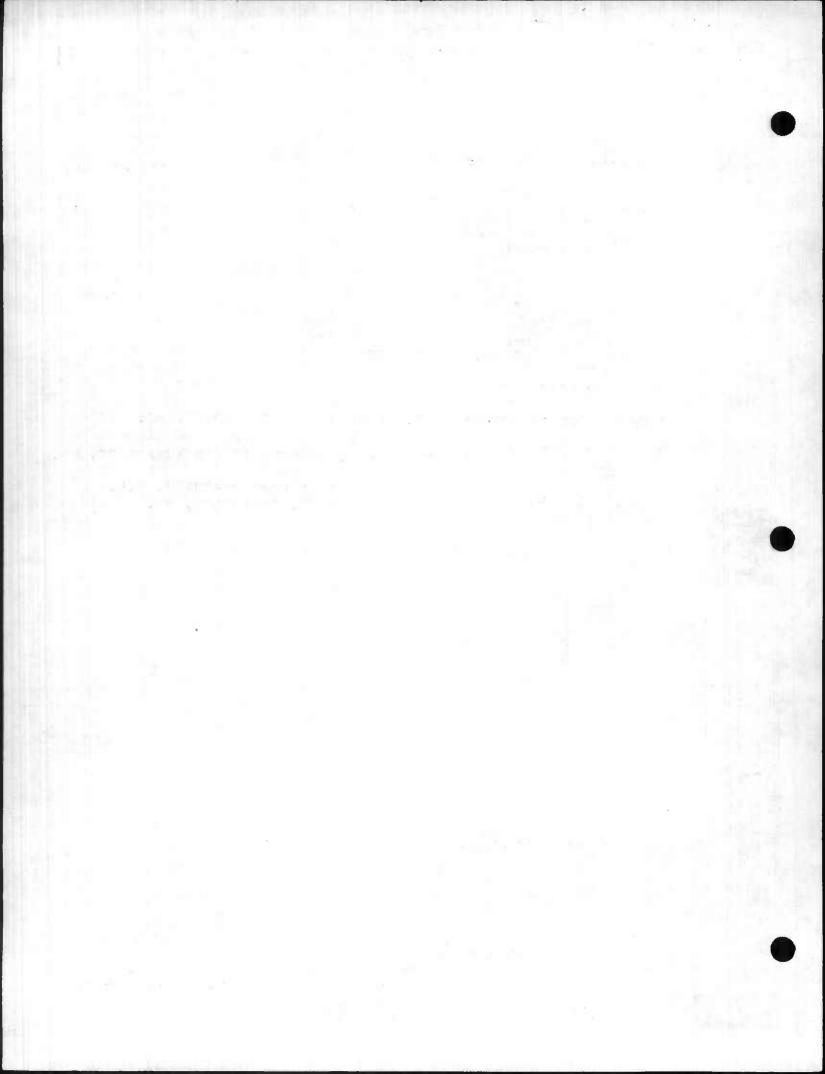
31. Date filed (Month, JAN 11 1999 32. Registrar's Signature

**DHMH 16 Rev 6/95** 



DHMH 16 Rav 6/95

Registrar



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2 Date of Death enth **Physician** Joseph McFadden /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** CATON MANOR GENESIS ELDERLARE BALTIMORE CIT Baltimore City 8. Date of Birth (Month, Day, Year) Oct. 14, 1913 If Under 24 Hrs. Hours Min, 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 6. Sax 7. Age (In vrs. last birthday) **Funeral** Deys Months 1 Q M 2 □ F 216-09-9933 85 Director Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Wed toll Examinar must be notified at 1 Yas 2 No Maryland Baltimore City Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue 21229 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) Black. White, etc. 1 Tayes 2 □ No If Yes, Give Year or Detes: WWII 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify À 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Machine Shop Machinist 0 11 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Kate Kelleher John P. McFadden 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Unknown Unknown 20b. Plece of Disposition (Name of cemetery, cremetory or othar place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 NOther (Specify) in state 21. Sign ture of Fundal Serice Licensee, Wade, Director 28 Partend Adda tomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Baltimore, Maryland 21201

Fert1. Enter the discussed the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, hock, or heert feilure. List only one cause on each line. Approximeta Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medicai Examiner Due to (or es e consequence of) Examiner hrone Sequentially list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ovonory Physician/Medical Que to (or as a conseque the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24e. Was en eutopsy pertormed? 24b. Were autopsy findings available prior to complation of ceusa of death? Completed 2 No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 27. Mapner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and dua to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29d. Data signed (Month, Dey, Year) 12-31-88 D21684 lymae Attending Docker 30. Neme and address of person who completed caysa of death (Item 23e) (Type, Print) RITCHIR GWT, PASADENA · V · CYRIAC. M.O 8109

State Registrar 31. Dete filed (Month, Dey, Year)

JAN 11 1999

32. Registrer's Signeture

this

s after deeth.

To the Hospital within 24 hours a To the Funeral L Hospital

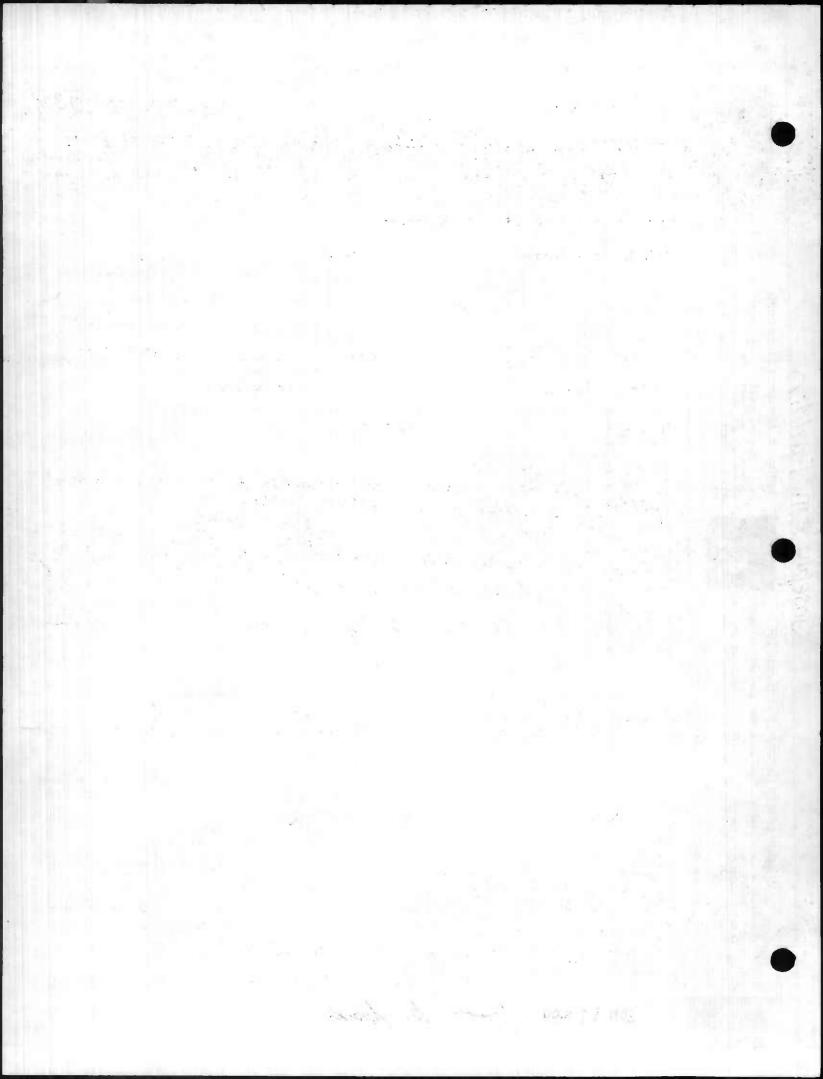
or Attending

cradder

permit. Peges 1 and 2 should be in Department of Health and Mentei Important: If item 27 is marked or

certificate be executed

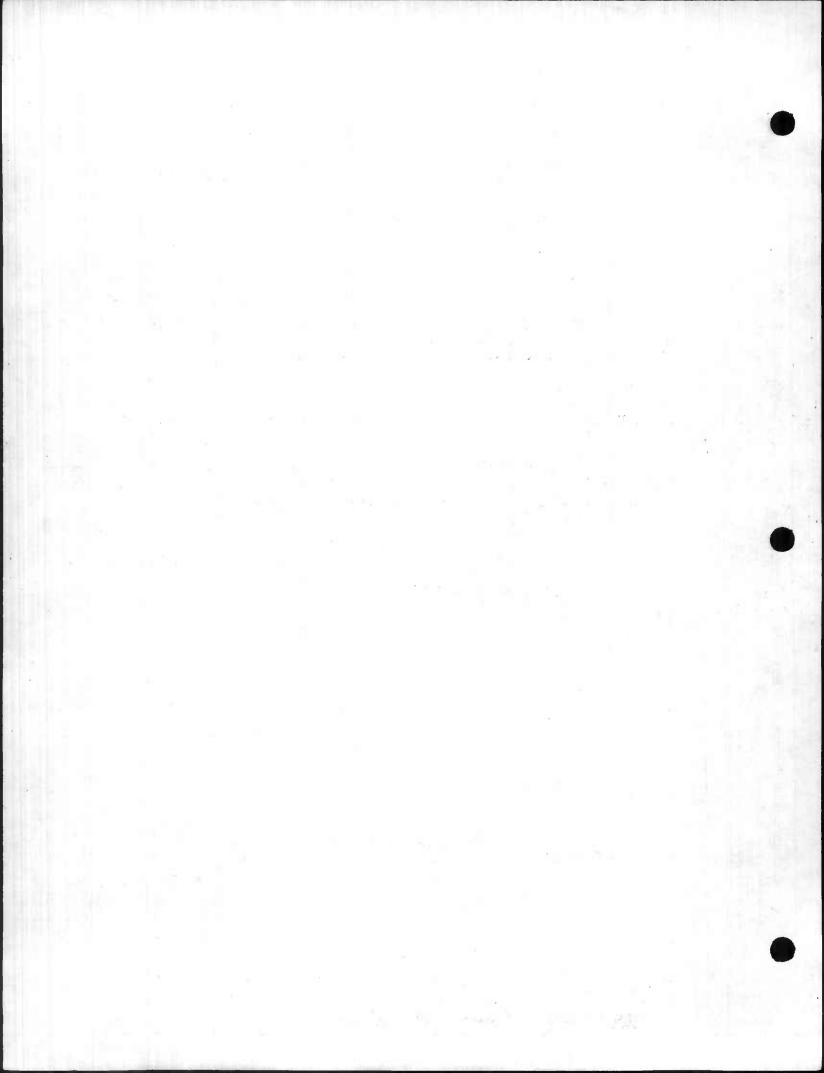
Division of Vital Records, P.O. Box 68760,



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 8

	Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of De	Reg. No. ath 3. Time of Death
sician edical	William Richardson		Month	Day Year 0752 AM BER 10, 1998
miner	4s Facility Name (If not institution, give street and number) 1403 ARGYLE AVENUE		own, or Location of Death TIMORE	h 4c. County of Death N/A
	5. Social Security Number  Unknown  Usual Residence of Decedent	Months Days Hours		th ly, Year) 9. Birthplace (State or Foreign Country) 9, 1948 unknown
	10s. State 10b. County 10c. City, Town		1 0.00	10d. Inside City Limits
Director	MD N/A Balt  10e. Street and Number	imore City		TV Yes 2 No 10g. Citizen of What Country?
ral Di	1403 Argyle Avenue	21217		USA
by Funeral	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Was Decedent Ever in U.S. Armed Forces?  17. Was Decedent Ever in U.S. Armed Forces?  18. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Wes Decedent of Hispanic O If Yes, specify Cuban, Mexics</li> <li>Yes 2☐No Specify</li> </ol>	an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, atc.  Specify: Black
Completed	15. Decedent's Education 16a, D (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during mo ife. DO NOT use retired)	ost of working	16b. Kind of Business/Industry
	Unknown College (1-4or 5+) Unknown	unknown		unknown
	17. Father's Name (First, Middle, Last) unknown	18. Moth	ner's Name (First, Middle, unknown	, Maiden Sumame)
2		Aailing Address (Street and Numb		er, City or Town, State, Zip Code)
		1 E. Fayette St	reet, Balto	., MD 21202
	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify) in State	hisposition (Name of crematory or other place)	Date	20c. Location - City or Town, Stete
Completed by Physician/Medical Examiner	23a. P. P. T. 1. Enter the disease or complications that caused the deeth. Do not shock, or heart fellure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a condition sellur cause)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the NARCOTIC INTOXICATION	HEMORRHAGE  Insequence of): Insequence of):	ti. 23b. Did	tobacco use contribute to the cause of death  Yes 2 No 3 Probably 4 Unknown  an autopsy primed?  24b. Were autopsy findings available prior to completion of cause
			104	of death?
Be	25. Was case referred to medical examiner?  Hospital:		ce of Death (Check only o	one)
2	ALD Tes 2 No 1 Inpatient 2 ER/Outp	atient 3 DOA Other: 4 N		dence 6 Other (Specify) how Injury occurred
Certification:	2 Accident investigation Found: 12/10/98 3 Suicide 6 Could not be 28e. Place of Injury - At home fam	7:30AM 10 Yes 20	28f. Location (	Street and Number or Rural Route Number.
200	4 Homicide building, etc. (Specify)		City or Ton	cgyle Ave. Palto. MD
edical	29a. Certifier (Check only one)	feath occurred at the time, date a or investigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
M	29b. Signature and title of certifier  10. Name and address of person who completed cause of death (Item 23a) (Type 1111 Penn	29c. License number O.C.M.E ppe, Print) Street, Baltimo	G	29d. Date signed (Month, Day, Year) DECEMBER 10, 1998  ad 21201
tate trar	31. Date filed (Month, Clay, Year)  32. Registrar's Signature	Sporks	- 4	

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Item: 29c per M.D G-767 1/11/99 reb 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month DEC Vaar **Physician** SOLOMON 9:00a HATTIE 3 98 /Medical 4a Facility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner University of Maryland Medical Center N/A Baltimore 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. Birthplace (Stete or Foreign Country) **Funeral** Days 1□M 2\ F Months Hours 68 Director 250-54-2214 S.C. 1-19-30 Usual Residence of Deceden permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Maddeal Exertine must be not? and any page. 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County 1 Yas 2 No MD. N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4637 MANORDENE RD. 21229 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No ff Yes, Give A Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Merital Status Black White, etc. 1 Never Married 2 Married 1 Yas 2 No ff Yes, Give 2 Yeer or Detes: Specify Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC Elementery/Secondery (0-12) Coilege (1-4or 5+) HOMEMAKER -11-18. Mother's Neme (First, Middle, Maiden Sumema) 17. Fathar's Neme (First, Middle, Last) Be JAKE CARTER JULIE WILSON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) MARY PITTS (DAUGHTER) 4637 MANORDENE RD. BALTIMORE, MD 21229 20b. Plece of Disposition (Nema of cematary, crametory or other pleca) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST VET. CEM.1-7-99 OWINGS MILLS, MD 22. Nama and Addrass of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signeture of Funaral Sarvice Licensas Decen 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or have failure. List only one cause on each line. Approximata Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical cerebral herniation Examiner Examiner hemorrhage Subarachnoid physician and the buriel-transit Sequentielly list conditions, if any, leeding to immediate causa. Entar Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) ettending p signed by the el Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown ò been sig 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? hes je 2 ils certificate her 1 Ves 250No 1 Yes 2 No Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this certifica stelly filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as etated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end manner stated. edicai 29e. Certifier

altimore, Maryland 21215-0020

The lew requires that the death certificete be executed

Records, P.O. Box 68760.

Division of Vital

State Registrar

GREENE STE: 125D 31. Date filed (Month, Dey, Year) JAN 1

29b. Signeture end title of certifiar

22 S.

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KAtrina

RESIDENT

BALTIMORE,

29c. License number

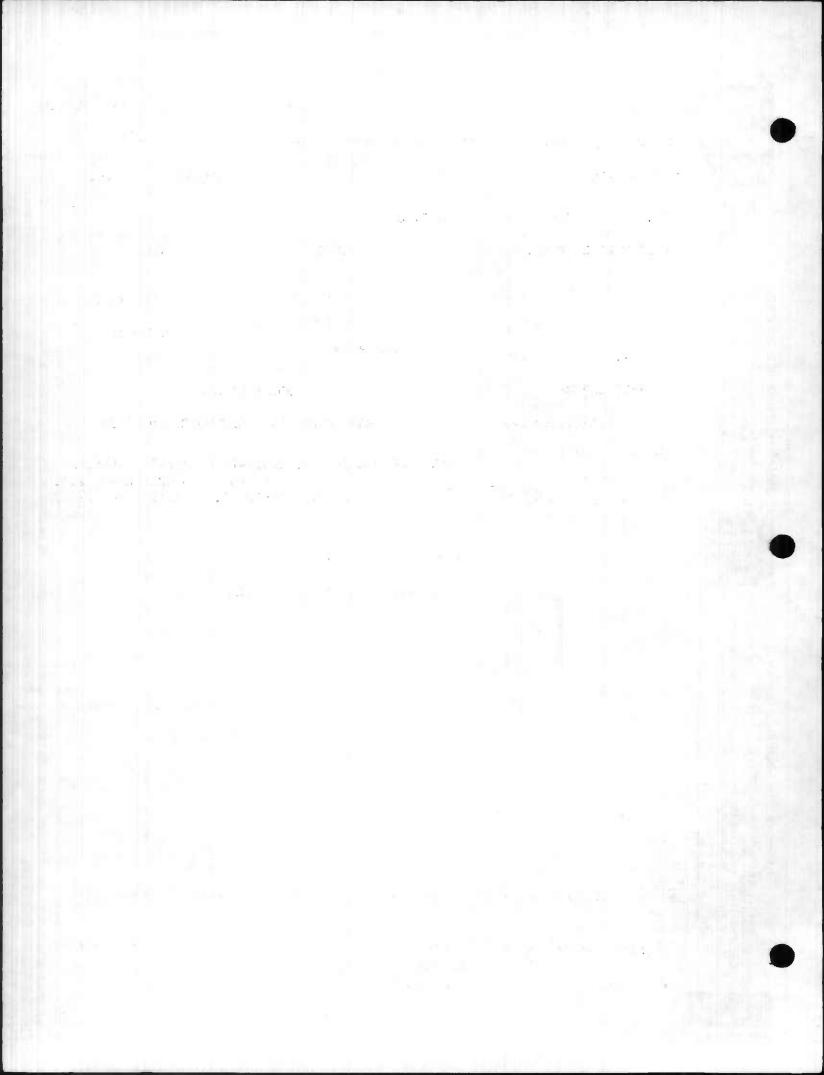
P-11466

29d. Dete signed (Month, Day, Year)

DEC 31, 1998

mur phy, mD

MARYLAND



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death

Month

98

4c. County of Death

19:02

12

4b. City. Town, or Location of Deeth

Physician
/Medical
Examiner

JAMES C. SHAW

4a. Facility Name (If not institution, give street and number)

**Funeral** Director

the Maryland ns 23a or 28a-f show traint be notified at with filed within 72 hours efter deeth items 2 5 "natural", traumatic event, the Medical then Hygiene. Pages 1 end 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

**Physician** /Medicai Examiner

The lew requires that the death certificete be executed been signed by the ette should be detached for After this certificate has Hospital or Attending Physicien: 24 hours efter death.
Funeral Director: After this certifica filled in by the funeral To the Hospital of within 24 hours of To the Funeral D completely filled

P.O. Box 68760,

Division of Vital Records,

ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL HOSPITAL If Under 1 Yaar If Under 24 Hrs. 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) 9. Birthpieca (Steta or Foreign Country) 1⊠M 2□F Deys Hours 214-20-4677 Yrs 74 PENNA. 12-9-24 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ANNE ARUNDEL MD ANNAPOLIS Completed by Funeral Director 1 ☐ Yes 2 KINO 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 894 MARENGO STREET 21401 USA 14. Race - American Indian, 12. Was Decedent Evar In U.S. Armed Forcas? 11. Maritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) Bleck, White, etc. 1 ☐ Never Married 2 ☑ Merried DYes 2 No f¥es, Give Year or Dates: W.W. II 1 ☐ Yes 2 🖾 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12--0-DOCKETT CLERK PATTEN OFFICE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be JAMES C. SHAW SR. ELLA MANN 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) or other train THELMA SHAW (WIFE) 894 MARENGO ST. ANNAPOLIS, MD 21401 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramovel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or METRO CREMATORY 12-30-98 BALTIMORE, MD 21. Signeture of Fundrel Sarvice License 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A.

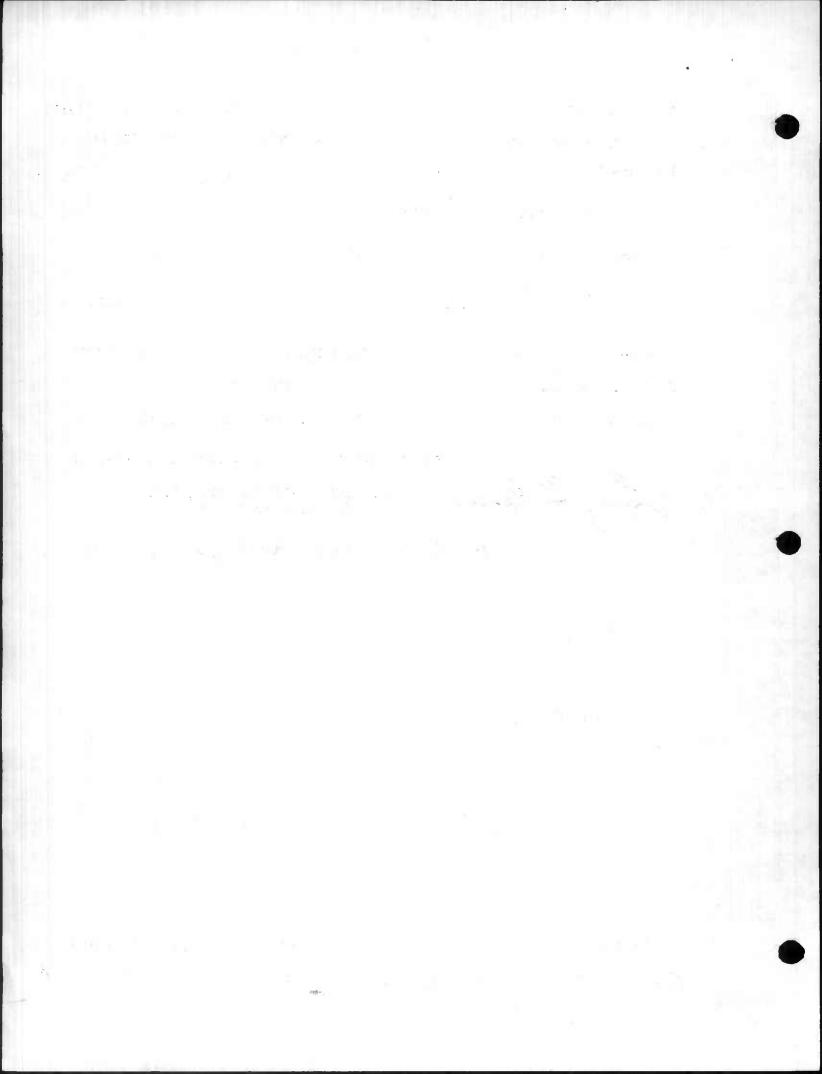
23a Antl. Enter tha diverse, or complications that coused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, 1401 shock, or heer tinure. List only one couse on each line. Approximeta Intervel Between Onset and Deeth Immediate Ceuse (Final OW MX diseese or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Plestal 1 Yes 2 No 3 Probably 4 Vnknown à 24b. Ware eutopsy findings evalleble prior to completion of ceusa of deeth? Be Completed 24a. Wes en eutopsy performed? 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Piece of Death (Check only one) Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 D Homicide Medicai 100 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Deta signed (Month, Dey, Year) Da754 Leya MD Jan, 7, 1999 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

GETHA RASA, 4367 HOWW Form Rd Bultmone MD-2/228

State Registrar

GETHA 31. Dete filed (Month, Dey, Year)

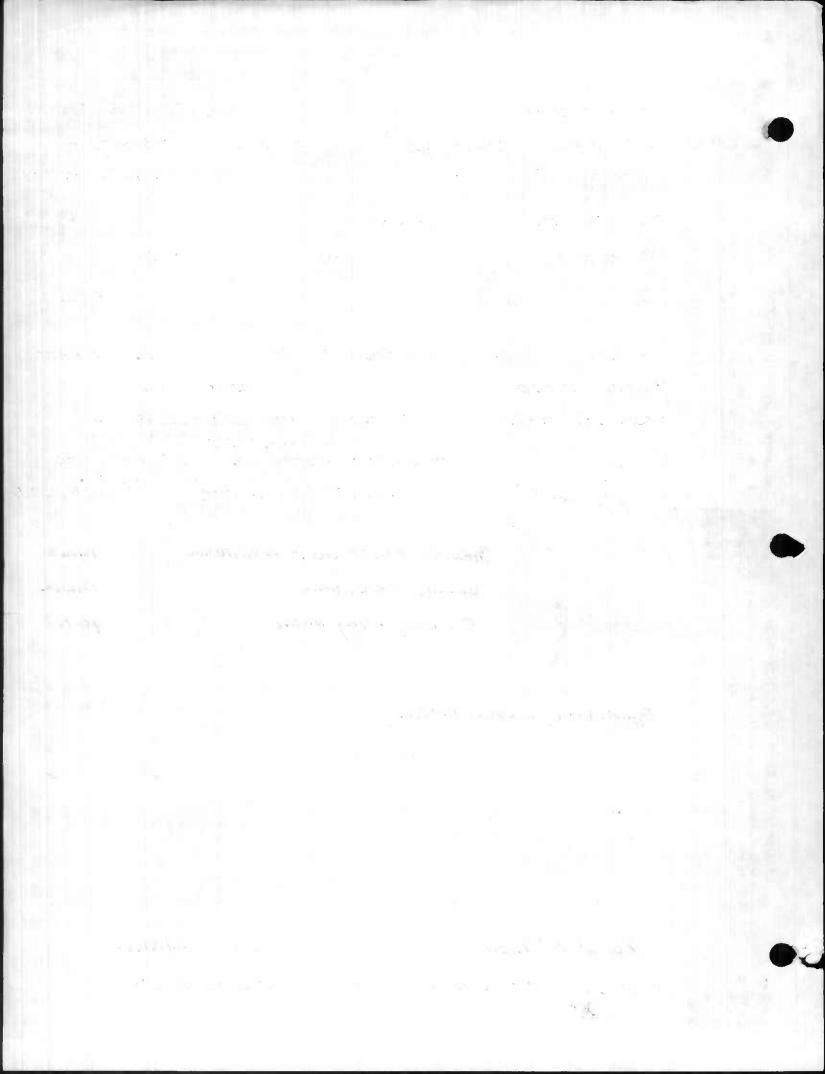
32. Registrar's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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	21. Signa e of	Funeral Sarvio	ce License	0	1				ss of Facility					
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Name (First, Middla, Last) 2. Date of Deeth 3. Tima of Death DECEMBER 16, 1998 CANDIDA JAMITO AGUILAR 9:20PM 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 3317 RANDALL ROAD SUITLAND PRINCE GEORGE'S If Undar 1 Year If Undar 24 Hrs.

Months Days Hours Min. 5. Sociel Security Numbar 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) 1 M 2 F 81 577-86-3286 SEPT. 22, 1917 PHILLIPINES Usual Rasidance of Decedant 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits MARYLAND PRINCE GEORGE'S SUITLAND N☐ Yes 2☐ No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 3317 RANDALL RD. 20746 USA 12. Was Dacadant Evar In U,S. Armad Forces? 11. Maritel Status Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien. Bleck, Whita, atc. 1 Never Merried 2 Married 1 ☐ Yes 2√√No If Yas, Give 1 ☐ Yas 2 ☐ No Specify: Specify: FILIPINO 3 Widowed 4 □ Divorcad 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th HOUSEKEEPING HOTEL INDUSTRY-PVT. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) EARNESTINE DAVIS / GRANDDAUGHTER 2601 NAYLOR RD. SE #2 WASHINGTON, DC 20020 20b. Placa of Disposition (Nama of 20a. Method of Disposition Deta 20c. Location - City or Town, Stata cematary, crematory or othar placa) 1 Burial 2 □ Cremation 3 □ Removal from State 12-22-98 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL 21. Signature of Funaral Sarvice License 22. Name end Addrass of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MARYLAND 20746 23a. Part1. Entar the disaasa, or complications that could dithe dieth. Do not anter the mode of dying, such as cerdiec or respiretory arrast, shock, or haart failura. List only ona causa on each line. Approximate Intervel Batween Onset end Deeth Cancer of Tongae with SIP Radical Neckley Immediata Causa (Final disaasa or condition resulting in daath) Dua to (or as a consequance of): Ih yonoma Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of): Rectal Becchi Ja ToPolyP Due to (or as a consequence of): Heufes Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evelleble prior to 24a. Was an autopsy performed? completion of cause of daath? 1□ Yes 2E No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical 26. Place of Deeth (Check only ona) Hospital: Othar: 4□ Nursing Home 5 Rasidance 6 □Other (Specify) 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Watural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifian 29b. Signeture and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) DEC. 22, 1998 omare

Records, P.O. Box 68760,

requires that the death certificete be executed physician and sthe burial-trans for use es 1 signed by the e ate has been signated page 2 should b certificate hes Division of Vital funeral Attending After death. To the Hospital or Attenditional within 24 hours efter death.

The Funeral Director: A completely filled in by the funeral completely filled in the funeral completely filled in by the funeral completely filled in the funer

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other than "natural, or ite any injury or other traumatic event, the Medical Examinations.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

2

Examiner

Physician/Medical

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Completed

Be

2

Certification:

edicai

with the Maryland

death

State Registrar

31. Data filed (Month, Day, Yaar) DEC 2 1 1998



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DR. KHOSROW DAVACHI 1328 SOUTHERN AVE. #202 WASHINGTON, DC

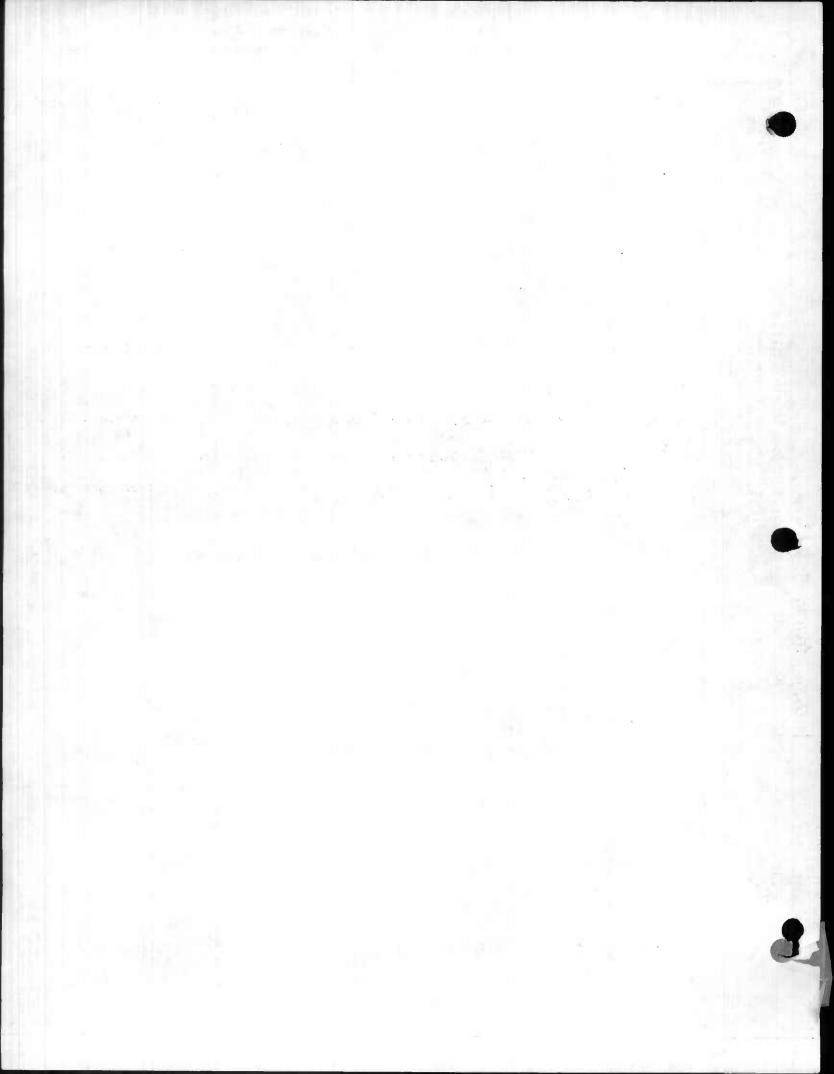
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11:20am Martin Clifford Bussard December 27 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) **Funeral** Deys Hours Months 1 MM 2 F Yrs Director 216-14-5270 Sept. 18,1919 Maryland Usuel Residence of Deceden death with the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits -how r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at 1 PTYas 2 □ No Director Mary land Washington Sharpsburg 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 21782 17418 Shepherdstown Pike United States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1⊠Yes 2□No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩idowed 4 Divorced Year or Detes: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Postal Service Mail Carrier permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: if Nem 27 Is merited ofthe any Injury or other traumented ofthe Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Minnie Golden Pearl Baker Martin Luther Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17418 Shepherstown Pike Sharpsburg Maryland 21782 Audrey M. Bussard (Daughter) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial Park 12-30-98 Hagerstown, Maryland 4 ☐ Donation \_5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Neme end Address of Fecility Osborne Funeral Home 425 S. C Williamsport, Maryland 21795 Conccocheague St. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or half teilure. List only one cause on each line. Approximate Interval Between Onset and Deat Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last and Due to (or as a consequence of): as the burial-trar the attending physician thed for use as the buria Physician/Medical Due to (or as a consequence of) Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached signed by 1 Yee 2 0 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? hronic been: hera The law this certificate has **page 2** 1 | Yes 2 | 160 1 □ Ves 2 □ No of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Dipatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Dete of fnjury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After Division Attending 5 Pending investigation 1 Matural Injun To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 11. Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Overagetor 30. Name and eddress of person pleted cause of death (Item 23a) (Type, Print), Robert Rotomac 1459 31. Date tiled (Month, Dey, Year) 32. Registrer's Signature State **DEC 28** Registrar

DHMH 16 Rev 6/95

Sussard, Martin



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death 1. Decadant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Belote Month 0900 UNICLE 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Death 800 LAUrel 57 ocomoke CIM Workester 8. Data of Birth (Month, Day, Year) If Under 24 Hrs. 6. Sex If Undar 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foraign Country) 10M 2XF Deys Months Hours 218-24. Yrs. 6 30 VIRGINIA Usuai Residence ot Decadant 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Workester ocomo le 10e. Street and Number 10g. Citizan of What Country? 800 57 2185 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 DNo If Yas, Giva Year or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Rican, atc.) Rece - Amaricen Indien Bleck, White, etc. 11. Marital Status 1 Never Marriad 2 Married 1 Yas 2 No Black 3 Widowed 4 □ Divorced Specify: 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind ot Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Abover Jou 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Sumama) William Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) daughter 3712 tallerson ocemake cin 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 □Ramovai from State 4 □ Donetion 5 □ Othar (Specify) 2/99 Pocomeke 22. Nama end Addrass of Facility 21. Signature of Funarel Service Licenses 22171 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haert tailure. List only one cause on each line. UngRoom 2 Approximata Intervel Between Onsat and Death Immedieta Causa (Final disease or condition rasulting in deeth) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa [Diseasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of). Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings availeble prior to complation of causa of death? 24e. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa raferred to medical exeminar? 28. Placa of Deeth (Check only ona) 1 Yas 2 No Othar: 4 Nursing Home 5 Aesidance 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28d. Dascribe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury et Work? Netural 5 Panding Invastigation 2 Accident 1 Yas 2 No 3 Sulcide 6 Could not be 28a, Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homloid

Box 68760. P.O. Division of Vital Records,

thet the deeth certificate be axecuted physician and the burial-trans signed by t peed page 2 hes certificate To the Hospital or Attending Phyalolan: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director,

**Physician** 

/Medical

Director

Funeral

by

Completed

Examiner

**Funeral** 

Director

them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mant be notified at

the Marylend

72 hours efter

permit. Pages 1 and 2 should be filed within.
Department of Health end Mental Hygiene.
Important: If them 27 is marked other than any Injury or other traumation.

**Physician** /Medical

Examiner

Physician/Medical

by

Completed

Be

Medical Certification: To

29a. Cartifiar (Check only one) 29b. Signeture e

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

A. Grasso, 145

Park 1998 32. Projetrar's Signatura

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Baltimore, Maryland 21215-0020

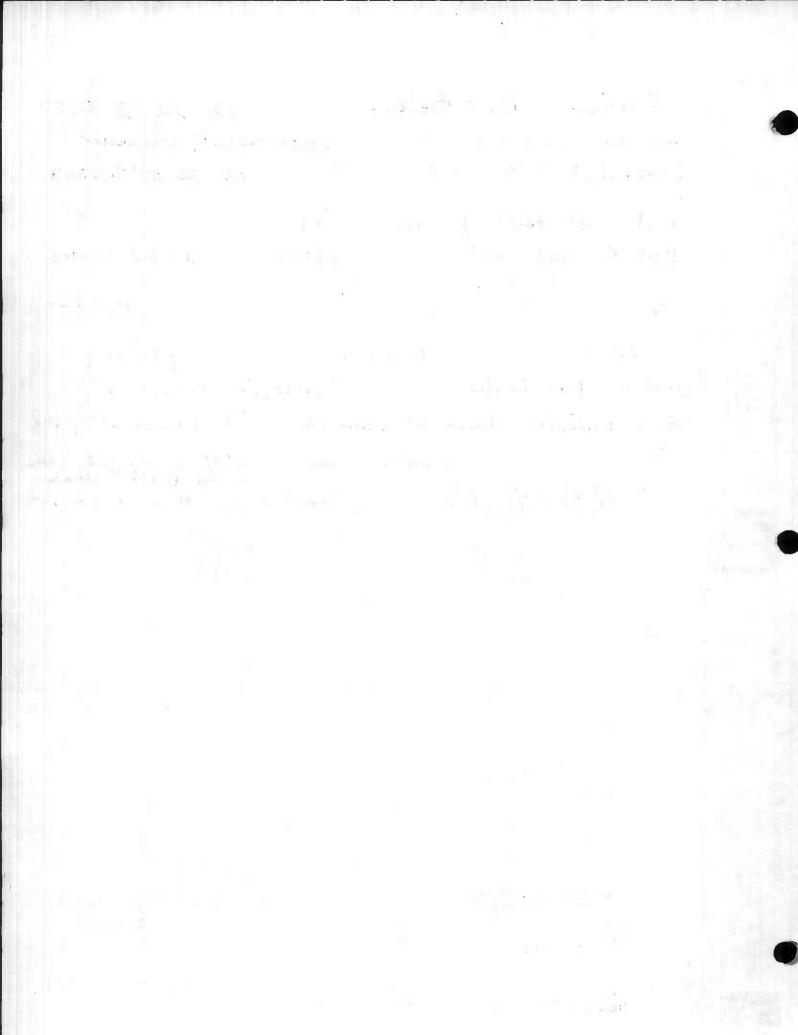
a	building, atc. (Specify)		City or Town, Stata)
1 Certifying Pt 2 Medical Exam	nyeiclan: To tha best of my knowledga, deat miner: On the basis of axamination and/or in end mannar stated.	n occurred et tha tima, data and place, vastigation, in my opinion, daath occur	, and dua to the cause(s) and manner as stated. rred at the time, data and place, end due to the ceuse(s)
rt title of certifier		29c. Licensa numbar	29d. Dete signed (Month, Dey, Year)

E, Carsoll St

1) 20507

Salisbury

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tims of Death **Physician** 27, 1998 December 11:15 AM BAILEY NORMAN /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury, MD Wicomico 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. 8/22/1908 5. Social Security Number 9. Birthpleca (Stata or Foreign **Funeral** 1**X**M 2□ F 186-09-7693 Penn. Director Usuel Rasidanca of Decedant 10a. State 10h County 10c. City, Town or Location 10d. insida City Limits Director 1 Deres 2 No Tyaskin Wicomico Md. 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 21865 P.O. Box 105 12. Was Decedent Evar in U,S. Armed Forcas? 130 Yas 2 □ No WW 2 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) Race - American Indian, Bleck, White, etc. 1 Nevar Married 2 Merried White 1 ☐ Yas 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes. Elementery/Secondary (0-12) Collega (1-4or 5+) Ret. Army Serviceman 11 17. Fsther's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Sylvia Katz Nathon Bailey 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Ststa, Zip Code, 19a. Informant's Name/Relationship (Type, Print) P.O. Box 105, Tyaskin. Maryland 21865 Catherine Bailey, Wife 20b. Placa of Disposition (Nama of cametery, crametory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Ststa 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/2/99 Tyaskin, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 22. Neme and Address of Fecility
Messick Funeral Home, P.O. Box 61 21. Signeture of Funaral Sarvice Licensee M00 - 417Bivalve, Maryland 21814 23a. Part 1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiec or respiratory street, shock, or heer fellure. List only one cause on each line. Approximete Intarvsl Between Onset and Death Cardiovascula Decesso immedista Causa (Final diseese or condition rasulting in death) Examiner Sequantielly list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequanca of): Part II. Other eignificant condition contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

physician and s the burial-transit

attending I

signed by the all

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cartificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complately filled in by the funeral director, p

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Completed

Be

Medical Certification: To

P.O. Box 68760.

Records,

Division of Vital

77 is marked other than "natural", or items 23s or 28s4 show traumstic event, the Medical Examiner must be notified at

filed within 7 I Hygiene.

Baltimore, Maryland 21215-0020

1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy

24b. Ware sutopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 No

25. Was case gerred to medical examiner? 1 Yes 2 No

27. Mannar of Death

1 (2 Natural

2 Accident

3 ☐ SuicIda

4 Homlcide

nue

5 Pending Invastigation

28a. Date of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Othar: 4₺ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 28d. Dascribe how Injury occurred

26f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a. Cartifier

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be detarmined

29c. Licansa number

29d. Date signed (Month, Day, Year)

. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Gregoria M. Belloso, MD - 5302 Chinaberry Dr., Salis., MD 21801

State Registrar

31. Deta flied (Month, Dey, Year) DEC 2 8 1998

32. Registrer's Signatura



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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Data of Deeth 1100 24 1998 BAKER December HERMAN 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) 10XM 2□ F Months Days Hours Min 77 MAR. 19, 1921 MARYLAND 222-14-3501 Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21813 10119 BISHOPVILLE ROAD USA 12. Was Decedent Ever In U,S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1942-45 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Merried 2 X Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 □ Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BANKER BANKING 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Н. KATTE DAVIS CARL BAKER 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 10119 BISHOPVILLE ROAD, BISHOPVILLE, MARYLAND 21813 PHYLLIS C. BAKER/WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 □ Cremation 3 □ Removal from State 12/29/98 BISHOPVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) BISHOPVILLE CEMETERY 22. Name and Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 colons thet cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on a still line. Approximate IntervsI Between Onset and Deet Enter the disease, or com or heert feilure. List only Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or es e consequence of): Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? 8☑ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? t □ Yes 2/2/No 1 □ Yes 2 □ No

**Physician** /Medical Examiner

signed by the a

cartificata

director.

funeral

or Attending Physician: effer death. Director: After this cartifica

24 hours a Hospital

To the To the To the

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Completed

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Certification:

Medical

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**Physician** 

/Medical

Directo

Funeral

20

Completed

Examiner

**Funeral** 

Director

Hem 27 is marked other than "naturel", or hems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

with the Maryland

death

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last physician Physician/Medical the use

Part It. Other etgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

reunine

25. Wss case referred to medical examiner? 1 ☐ Yes 💨 d No

27. Menner of Death 5 Pending investigation 1@Neturel 2 Accident 3 Suicide 6 Could not be determined 4 - Homicide

Hospital; 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

\*\*Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, end due to the cause(s) and menner as stated.

\*\*The description of the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner in the cause(s) and manner stated.

\*\*The description of the basis of examiner: On the basis of examiner in the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifie

29c. License number 5361

2 No

29d. Date algned (Month, Dev. Year) 98

10 71 VA

31. Date filed (Month) 2 8 1998 State Registrar

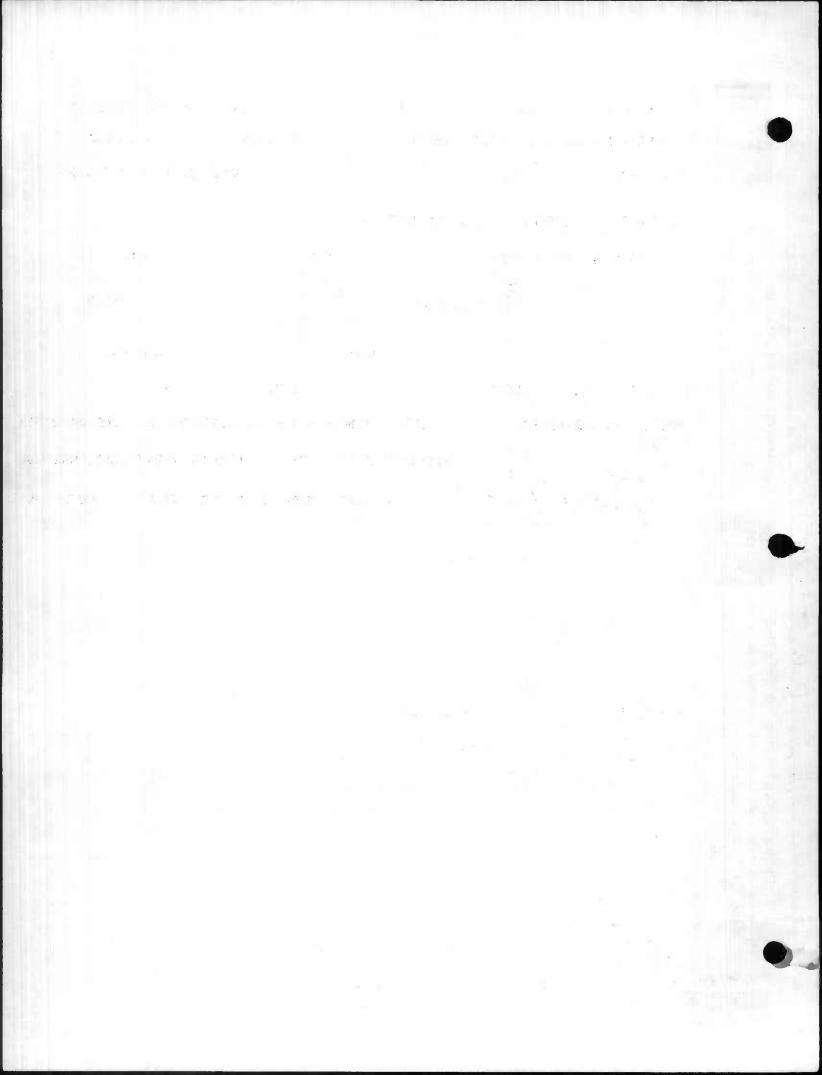
29e. Certifier

(Check only one)

32. Aegistrer's Signeture

ss of person who completed causa of deeth (Item 23e) (Type/Print)

28c. Injury et Work?



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** RAY BUNTING 12:45 PM LANA DEC. 22 1998 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12102 GODFREY-BUNTING ROAD BISHOPVILLE WORCESTER If Under 1 Yeer If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) NOV. 23, 1949 Birthpiece (State or Foreign Country)
 MARYLAND 5. Social Security Number **Funeral** Days 1□ M 2፟M F Months 49 Yrs. Director 218-48-6840 Usuel Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MARYLAND WORCESTER BISHOPVILLE 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23s or the Medical Exercines roust be r 12102 GODFREY-BUNTING ROAD 21813 USA Pages 1 and 2 should be filed within 72 hours after death a neat of Health and Mental Hygiene.
and: If item 27 Is marked other than "natural", or items 23, and it is death traumatic event, the Mentel Exercise must up or other traumatic event, the Mentel Exercise must Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. 14. Race - American indien, Armed Forces Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 🖾 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 REALTOR REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) P WALTER BUNTING SAVAGE Н. N. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) WALTER H. BUNTING/FATHER 12102 GODFREY-BUNTING ROAD, BISHOPVILLE, MD 21813 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 12/23/98 SALISBURY, MARYLAND 22. Name end Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 Enter the disease, or complications that odused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** Metastatic Immediate Cause (Final disease or condition resulting in death) /Medical ancen on Examiner Due to (or es a consequença of): Examiner g physician and as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): use signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Division of Vital Records. by Completed 24a. Was an autopsy 24b. Were autopsy findings avelleble prior to completion of cause of death? hes page 2 : 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical exeminer? funeral director Be 26. Piace of Death (Check only one) No No Hospitai: Other: 4 Nursing Home 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27, Menner of Death Certification: 28c. Injury et Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation efter deeth. Director: Aft 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and piaca, and due to the ceuse(s) and menner as ststed.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and placa, and due to the cause(s) and manner steted. Medical completaly (Check only one) within 2 ŝ 29d. Date signed (Month, Dey, Year) 0 Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Solish, MN 21801

145C.

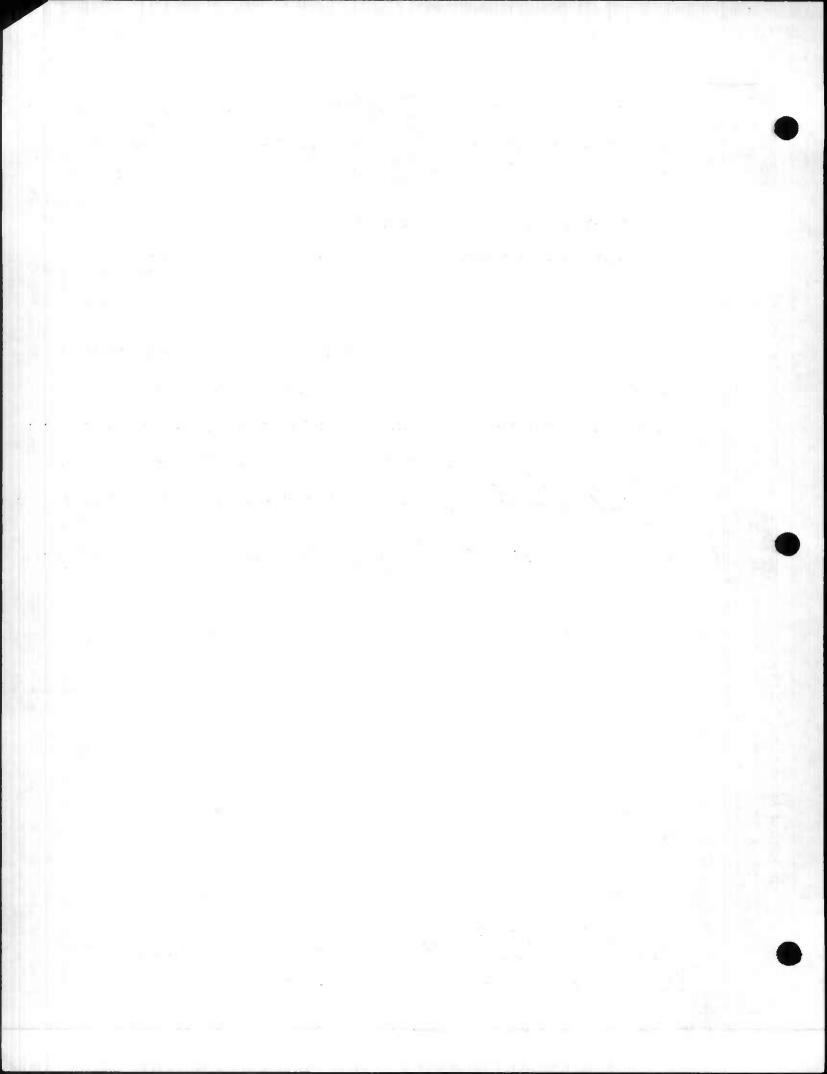
32. Registrar's Signature

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State Registrar Walle

31. Dete filed (Month, Day, Year)
DEC 2 3 1998

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 09:30AM Physician BOBLETT, SR. DECEMBER 28, 19918 HERBERT /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, 4c. County of Death Examiner MARYLAND HOSPITAL CENTER PRINCE GEORGES SOUTHERN CLINTON 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 9. Birthplace (Stata or Foreign Country) West Virginia 7. Age (In yrs. last birthdey) **Funeral** Months 100 M 2□ F Days Hours 232-64-4188 57 Director Usuai Residence of Deceden the Marylend 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow trsumsite event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Charles Waldorf 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20601 U.S.A. 2502 Lisa Drive Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11 Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours efter on ord Health and Mental hygiene.

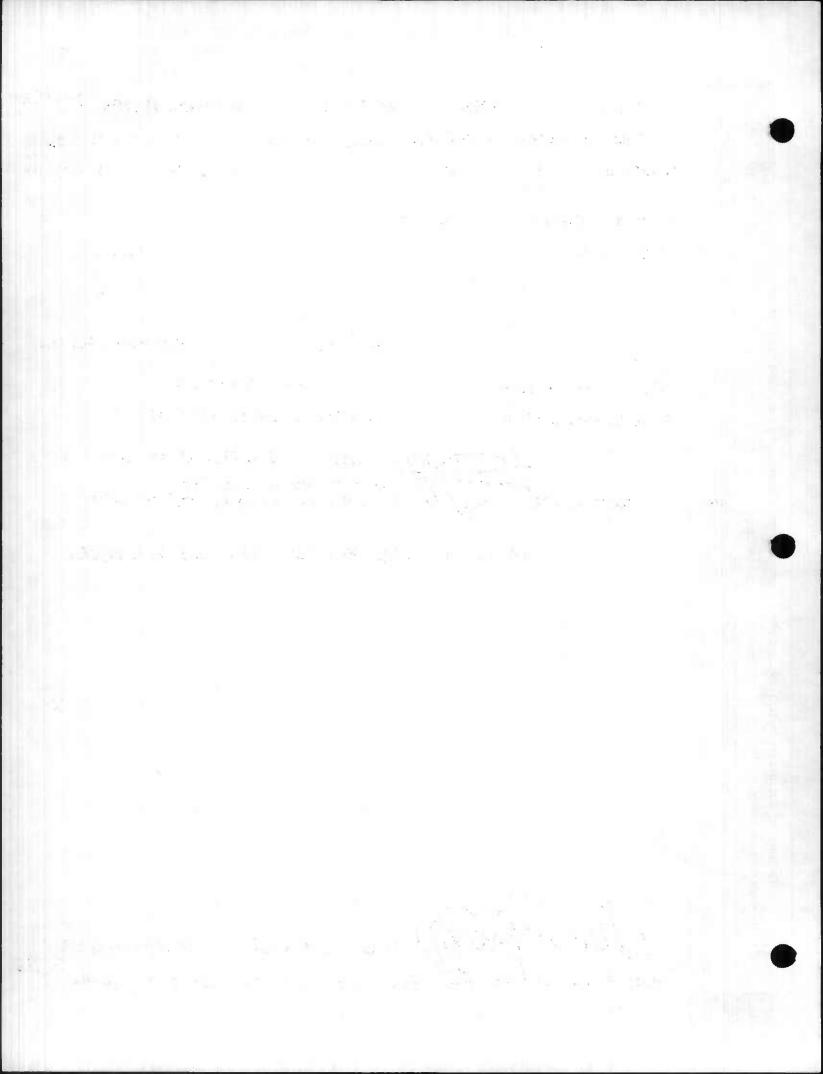
nt: if fem 27 is marked other than "natural", or fter it fem or other traumals event, the Medical Examinatiny or other traumatic event, the Medical Examinatiny or other traumatic event, the Medical Examinatiny or other traumatic event, the Medical Examinating 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Eiementary/Secondary (0-12) College (1-4or 5+) Washington Gas Co. Service Man 12 18. Mother's Name (First, Middla, Meidan Sumama) 17. Father's Name (First, Middla, Last) Be Pearl Mae Milsap Charlie Dillard Boblett 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2502 Lisa Drive, Waldorf, Maryland 20601 19a. Informent's Name/Relationship (Type, Print) Anita L. Boblett/Wife 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State permit. Page Department of Important: If any Injury or odice. Waldorf, Maryland Jan. 01,1999 Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service License The Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, Maryland 20604 mew DAVID A. GOFF MO/10/95/ Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceuse IVe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel . HYPERTENSIVE ARTERIOSCIEROTIC CARPIOVASCULAR DISEASE disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner physicien and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): ettending p the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy peen 1 Yes 200 No 1 ☐ Yas 2 ☐ No f or Attending Physician: after death. Director: After this certific funeral director, 25. Was case referred to medical examiner?

1 2 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Neturel 5 Pending 2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture ar ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who compi PRIVE CHEVERLY MARLO GOLLE 3001 HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 4 1064

	4	0	/4		,	Cen	tificate of	Death (	,	Reg. No.	J U 19	1004
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6	Examir		4a. Facility Nema (If not Institution, give	street end number)				4b. City, Town, or Lo	cation of Daet	h 4c. C	ounty of Death	
			6000 Sellner La	ne				Clinton		P	rince G	eorges
	Funeral		5. Social Security Number 6. S	ax 7. Ag	e (In yrs. last bi	rthdey)	If Under 1 Yaar Months Days	If Undar 24 Hrs.	8. Data of Bir (Month, De			elece (Stete or Foreign
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	Aaryla sho	ō	Maryland Prince Go	orgas	Clint		ation					1 Vas 2 No
	r 28a-f show	Director	10e, Street and Number	orges	CITIT	.011	10f. Zip Coda			10a Citina	6 14th - 1 C	
	Wig-	ā	6000 Sellner Land				Tol. Zip Coda	2073	5		en of What Cour ed State	
	leath w	era	11. Merital Status	12. Wes Decedent I	Ever in U.S.	13 W	les Decedant of				Race - Americ	
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Maryland 21215-0020	"naturel".	pe pe	**	Yaer or Datas:	100	Danada	natio Univel Occur	nation			DLA	
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	s 1 and 2 should f Heelth and Mer tem 27 is marks other treumetic		Velma Godfrey	/ Sister				Lane, Cl				
re,	f He frem		20a. Method of Disposition		20b. Place o	f Dispos	ition (Nama of atory or other pla		Dete		ation - City or To	
Baltimore,	permit. Pages 1 and 2 Depertment of Heelth a Important: If item 27 is eny injury or other tre once.		1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify					Cemetery1:	2/22/08	Custo	land M	[awv1 and
alti	mit.		21. Signature of Funeral Service Licen		LINCO		Nama and Addr		2/22/30	Sull	. Tand, F	laryrand
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	To the Hospital or Attending Phywibin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	0	29a. Cartifiar 1 Cartifying Phy	sician: To the best o	f my knowledou	death	necurred at the #	ma, data and piace, a	and due to the	cauca(a) a	nd manner en -	stad
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	14)		30. Name and A dress of person while	on pleted cause of de	ath (Itam 23e)	(Type P	nint)	011.0			1 /	10
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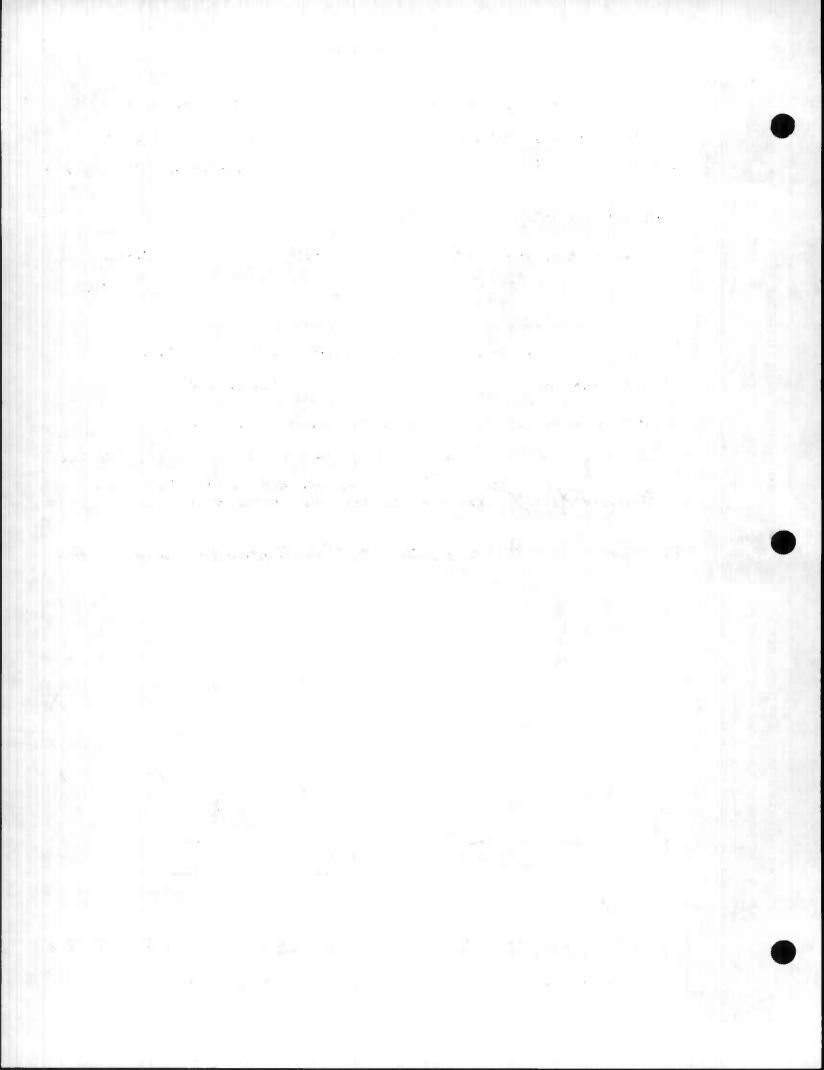
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State of Maryland / Department of Health and Mental Hygiene 9 8 4 10 5 5 Certificate of Death 3. Time of Death 1. Decedent's Name /First Middle Last) 2. Date of Death **Physician** 10:35 AM Runkle December 17, 1998 Roswell Boyer /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 44815 Three Coves Road Hollywood Mary's ff Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 94 577-18-7750 Director December 31, 1903 Pennsylvania Usual Residence of Decedent the Maryland r 28a-f ahow 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2♥ No Maryland St. Mary's Hollywood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or flame 23a or edical Examiner must be r permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or flarse 23a says highery or other traumatic avant, the Medical Executive month. 20636 44815 Three Coves Road Funeral U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 4 Years Training Staff Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ezra Clinton Boyer Elvina M. Runkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore C. Boyer/Son P.O. Box 524, Waldorf, MD 20604 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cemetery 12/28/98 | Arlington, Virginia 22. Name and Address of Fecility Mattingley-Gardiner Funeral Home, P.A. 23a. Part1. Enter the disease, of complications that ceused the deam. shock, or heart failure. List only one cause on each line. P.O.Box 270, Leonardtown, MD 20650. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Betw Onset end Death **Physician** fmmediate Cause (Final disease or condition resulting in death) osclarote Cardwarendon desens /Medical Examiner Due to (or as a consequence of) Examiner certificate be executed nding physician and use as the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or es e consequence of) signed by the a Part ff. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? been sign 24a. Was an autopsy performed? Completed The law certificata has b lirector, paga 2 sl 1 Yes 27 No 1 Yes Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 27. We per of Death Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funera 28c. Injury at Work? 1 Naturai 5 Pending Investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number m DA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, MD Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) DEC 2 1 1998 32 Registrar's Signature State

Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day **Physician** Edna Marie Brown DECEMBER 22,1998 6:55 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 KF 212-24-0030 Director 80 28-Jun-18 **Pennslyvania** Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 1 ☐ Yes 2 No Director Allegany Maryland frostburg 10e. Street and Number 941 West Finzel Road 10f. Zip Code 10g. Citizen of What Country? 8 Нете 23а 21532-14. Race - American Indian, death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural". or Many Injury or other traumatic averages. Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Deal Mary Baer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wanda Coughenour Daughter 941 West Finzel Road Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Dete 1 ⊠ Burial 2 □ Cremation 3 □ Removel from Stete 4 Donation 5 Other (Specify) 24-Dec-98 Pocahontas, Pennsy ania Greenville Lutheran Cemetery 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility loku ; Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Examiner Examiner APTERIOSCUEROTIC CARDIOVAS CULAR DISCUSE physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown MOISMEDICIPHH Records, Š The lew requires 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS 24a. Was an autopsy performed? Completed page 2 Z LI No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 LNO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 26a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 5 Pending 1 DNatural Hospital or Attanding 24 hours after death.
 Funeral Director: After 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 2 4 Homicide filled in 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar PHYSICIAN

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ress of person

JOSE

050844

LOVERIA JR., M.D. GIZ SETON DRIVE CUMBERIMO, MO

DECEMBER

,1998

Edna Marie Brown

Sacred Heart Hospital Cumberland Altegany

212-24-0030 80 28-Jun-18 Pennslyvania

Maryland Allegany Frostburg

941 West Finzel Road

21532- U.S.A.

8 Homemaker Homemaker

William Deal Mary Baer

Wanda Coughenour Daughter out West Enzel Road Frostburg Maryland 21532-

Stock Straight Stock Straight Straight

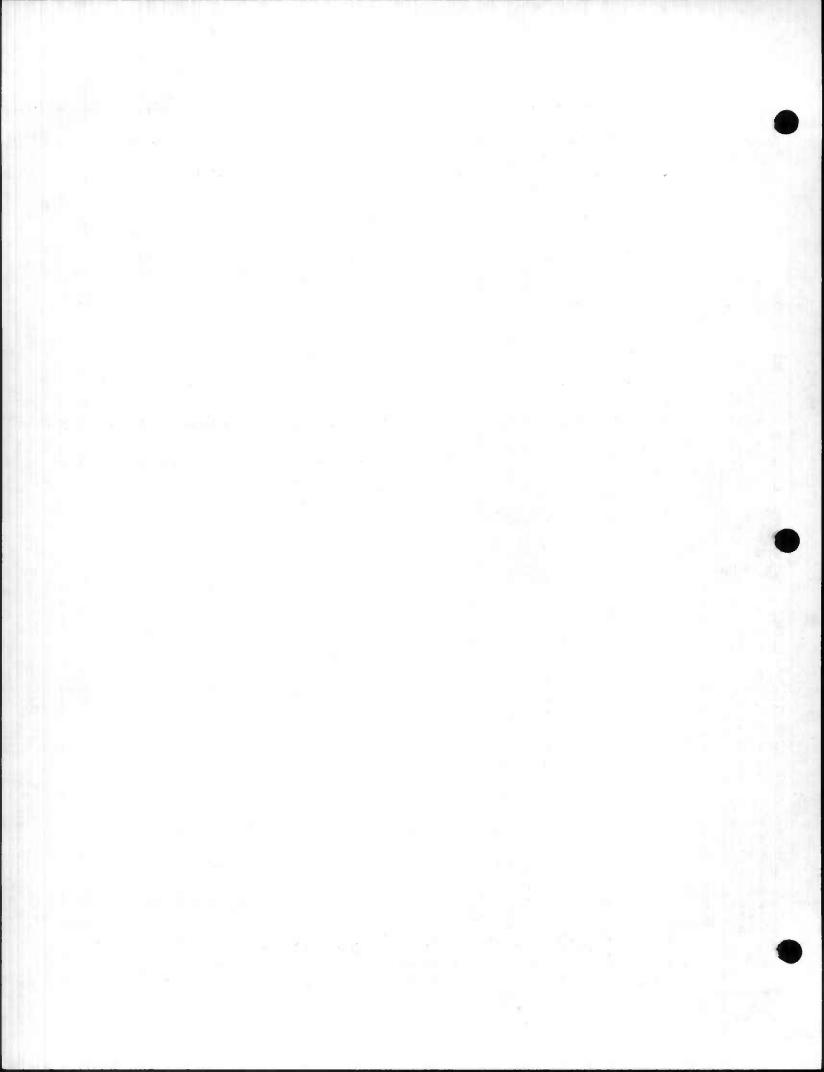
Greenville Lutheran Cemeter, 24-Dec-98 Pocahonias, Pennslyvania

Durst Funeral Home, 57 Frost Ave., Frostburg. MD 21532

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ч	Exami	ner	4a. Facility Neme (If not Institution  Devlin Mano)					-1-51	Location of Death	4c. County o	
Н			5. Social Security Number	6. Sex		rs. last birthday	If Under 1 Yea	Cumberl		Alleg	-
L	Funeral Director		214-28-6637 Usual Rasidance of Decedant	1□M 2ØF	67	Yrs.	Months Day			, 1931	Birthplaca (Stata or Foreign Country)     MD
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	Mary	to	MD Alle	gany		Cumbe	erland				1 XYas 2 No
	r 28s	Director	10e. Sireet end Number				10f. Zip Coda		1	Og. Citizen of Wi	net Country?
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20	72 hours efter deeth with the Maryland "natural", or itema 23a or 28a-f show solical Examiner must be putified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Mai  3 □ Widowed 4 □ Divorces	Armed F ried 1 Yas If Yas, G	2 📉 No iiva		Was Decedent of if Yes, specify Cu	Hispanic Origin? (Sben, Maxican, Puer	Specify Yes or No- rto Rican, etc.)		- American Indian, , White, etc.
9	hour	Pa		Yaar or I	Datas:	18e Door	edant's Usual Occi	unation		10h Wind of Fluo	white
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pu	be filed ital Hygi of other event, II	Be C	17. Father's Neme (First, Middle,	Last)				18. Molher's Na	ma (First, Middla, N	faidan Sumame	)
Maryland	should be a and Mental I marked of umatic eve	To	H. Clifford	Spiker				Mary F	Kay (David	dson)	
lan	0 0 0 0		19a. Informant's Name/Relations	ship (Type, Print)		19b. Malli	ing Addrass (Stree	et and Number or A	ural Routa Number,	City or Town, S	tata, Zip Coda)
3, 2	s 1 end if Heelth item 27 other tr		Robert E. Bow	man-husba					reet; Cum	berland	, MD 21502
Baltimore,	permit. Pages 1 en Department of Heel Important: If item 2 any injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	3 □Removal from Specify)	State		osition (Name of matory or other pl 7's Cemet		Data 2		lty or Town, State
Balt	permit. Departr Importr any inje		21. Signeture of Funeral Sarvice	Licansee	0010	M- 2	2. Name end Add	ress of Fecility 11i Funer 1and, MD	cal Home, 21502		
	Physician /Medicai Examiner	ľ	23a. Part1. Entar the disease, o shock, or heart failure. List Immediate Cause (Finel disease or condition resulting in deeth)	a	0	Or as a conse	mu	ring, such as cardie	c or raspiratory arra	st,	Approximata interval Between Onset end Deeth
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<u> </u>	The cate	Co							1□ Ya	s 25 No	1 ☐ Yas 2 ☐ No
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ysician: The is certificate he director, page	Be	25. Was case rafarred to medica examiner?	Hospital:					ath (Check only one		
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completely filled in by the funeral director,	ation: To	1 Yes 2 No  27. Mannar of Deeth 1 Naturat 5 Pendir 2 Accident Investi	28a. Dete	inpatiant 2[ of Injury oth, Day Year)	28b. Time o	f 28c. inju	nar: 4⊠ Nursing I ury et ork? ] Yas 2 □ No	doma 5 ☐ Resider 28d. Describe ho	nce 6 □Othar w injury occurred	(Specify)
Divis	ital or Atterns after de al Directo	Certification:	3 Suicide 6 Could 4 Homicide datarr	lined 28a, Place build	ing, atc. (Spec	eify)	reat, factory, office		City or Town	, Stata)	or Rural Routa Number,
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	Jus		30. Nama and address of person	070	sa of death (Ite	em 23a) (Type,	Print) 121 H	uy L	2 / 2/2	ME	2/502
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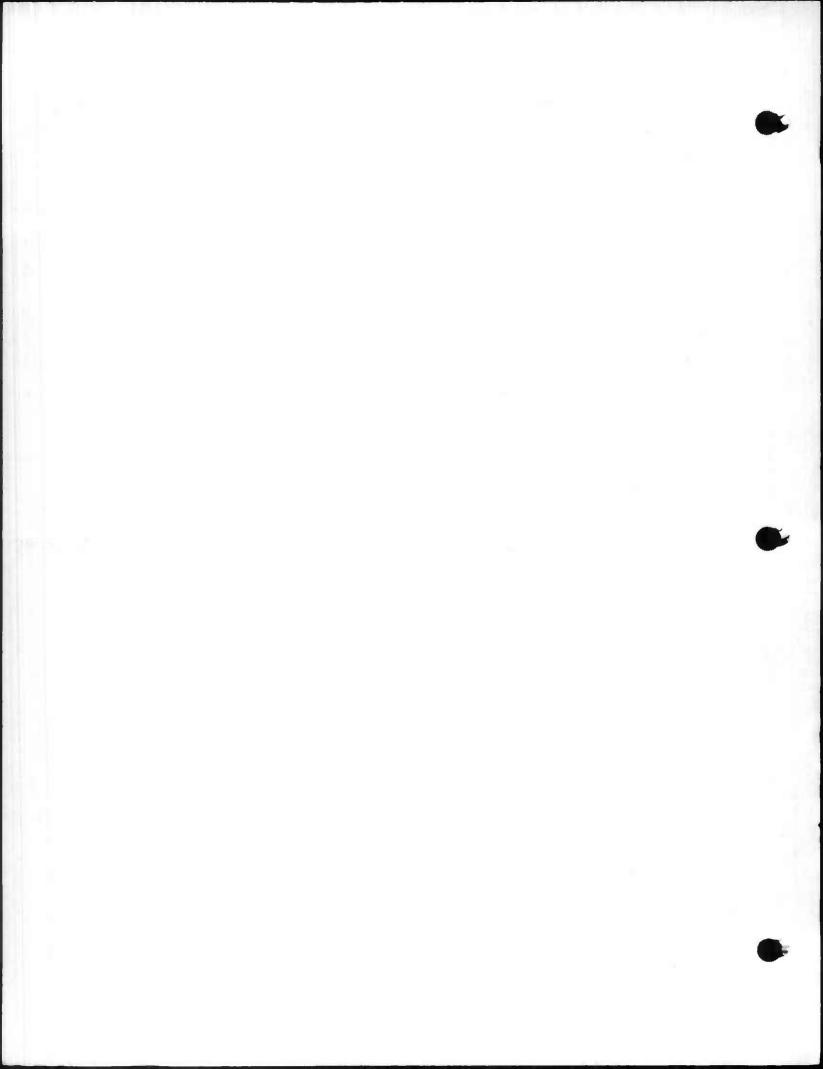
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	REC	10a. STATE 10b. COUNT		10	c. CITY, TOWN	OR LOCA	TION					10d. INSIDE CITY	_
permit. Pages		WV Mine	eral		Ke	eysei						YES 2 NO	
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21 tal or 1 for th	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do I	Norker	)		. [					
AND 2 he hospital detached for	COMPL	12th.  17. FATHER'S NAME (First, Middle, Last)		case	MOLKEL	Soc	ial Serv	_		e Gov	rernn	ent	
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MAR retained 5 should		John R. Barger (	Son)				ter Stre				267	126	
ORE, 6 may be ector, page	3	20a. METNOD OF DISPOSITION	20	b. PLACE AND						CATION C			_
e 6 m		4 Donation 5 Other (Specify) Crematory or other place)  Oueens Point Cemetery 12/23/98 Keyser, WV 26726											
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within 24 hours npletely filled in t cremation, or rel		23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that cause List only one cause on a	7/D/	Do not ente	ir the mo	S. Miner ode of dying, su	cal Such as c	Street. ardiac or reapi	Keyse	et,	Approximate Interval Between Onset and Daeti	
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that the ed by the th and M	OICAL	PART II. Other algorificant condition	na contributing to death i	but not reaul	ting in the	inderlyin	g cause given i	in Part I.	24a, WAS AN PERFOR	MED?	6	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	_
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Plas la	\{	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE C	26. PLACE OF			UNCERTA	IN L	1				_
- F 2 2 2	Sic	EXAMINER? 1 ☐ YES 2 ☑ NO	HOSPITAL:		OTHE	R:	e 5 🗆 Rasidence	i o	h (0/k-)				-
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DING PHYS After this death with	ΒY	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)		INJURY M		YES 2 NO						
TTENDII TOR: A after de	TED	3 Suicide 8 Could not be 4 Nomicide detarmined	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, fi icify)	erm, street, fe	ctory, offic		28f. L	OCATION (Street a ty or Town, State)	nd Number o	r Rural Roo	rte Number,	
B DIA	2.E	29a. CERTIFIER (Check only	SICIAN: To the best of my know	viedge, daath o	coursed at the	time, date	and place and de	ue to the	Supple and man	Der an etele-			-
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THE OT THE DE filed MADOR	O BI	1	11/2	171			D1876				2/22	36167.102	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DEC 2 3 1998

A. Ravers, M.D. Memorial Hospital, 400 Memorial Ave., Cumberland, Md21502

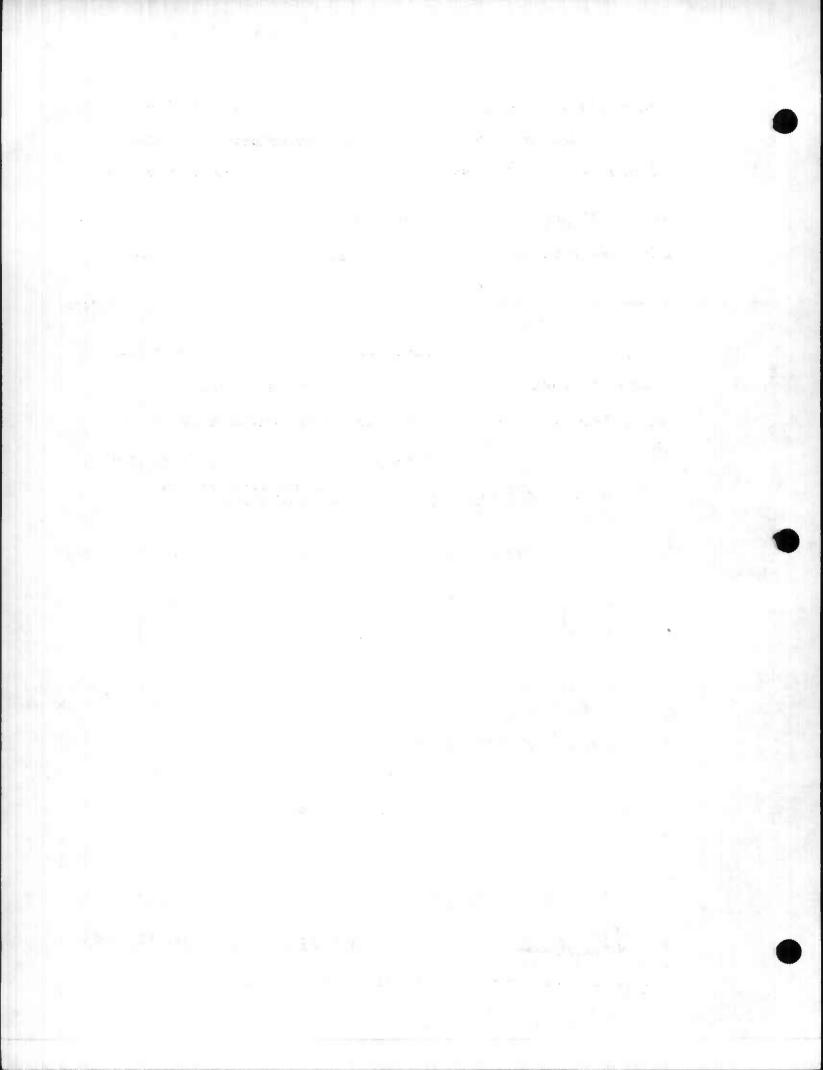
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State of Maryland / Department of Health and Mental Hygiene

December Name   Series March Latt)   Control						,		rtificate o	f Death		eg. No.	-	1069
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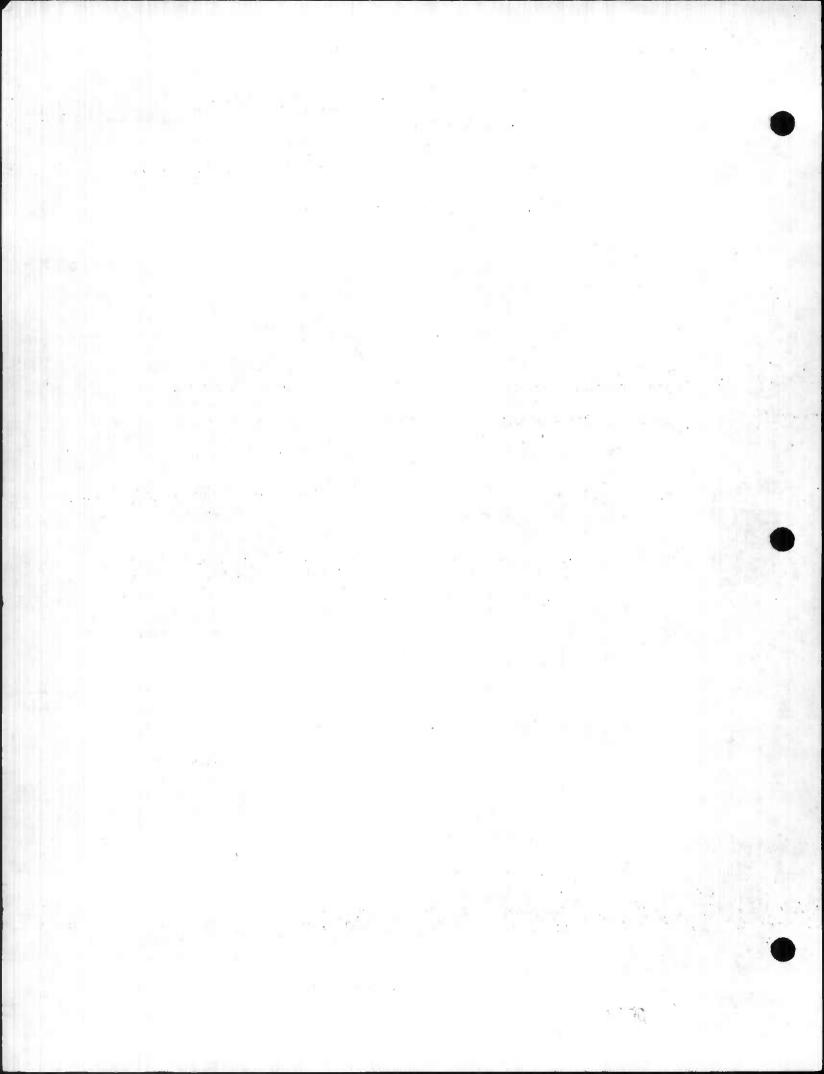
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Division of Vitai Records, P.O. Box 68760,

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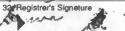
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11. Maritel Status  1 Never Merried 2 Merrie  3 Widowed 4 Microced	12. Wes Decedent I Armed Forces?  od 1 Yes 2 N If Yes, Give Yeer or Detes:		Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	e - American Indien, ck, White, etc.	
15. Decedent's (Specify only highest	s Education	16a. Dece	edent's Usuel Occu	pation	kina	16b. Kind of Bu	usiness/Industry
Elementery/Secondery (0-12)	College (1-4or 5	)+)		during most of wor ed)	KING		epartment of
17. Fether's Neme (First, Middle, Li	2 years	Н	lead Cook	18. Mother's Ner	ne (Eiret Middle	Agricu	
Robert		Blackwell,	Sr.	Mary	Elean		Thomas
19a. Informant's Name/Relationshi				t end Number or Ru			
Stacey Charlene	Parker (dau	ghter) 384	7 - 26th	Avenue, I	Cemple H	ills,Man	ryland 20748
20a. Method of Disposition		20h Place of Disp	osition (Name of	Jan.5	Date		City or Town, Stete
4 Donation 5 Other (Spe		Metropo	litan Cr	ematory	1777	Alexand	ria, Virginia
21. Signature of Funeral Service Li	censee	11 2	2. Name end Addr	ess of FecilityRot	ert G.	Mason Fu	uneral Home,In
Mobert	U. Sul	6 1	661 Good	Норе коас	I,S.E.;W	ashingto	on,D.C. 20020
shock, or heert failure. List of Immediate Cause (Final disease or condition resulting in death)	Intervel Between Onset end Deeth						
	b						
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a conse	quence of):				
Cause (Disease or injury	С	Due to (or es e conse					
thet initiated events			quenca or:				
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resulting in death) Last				iven in Pert I.			ntribute to the cause of deal
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Pert II. Other significant condition				iven in Pert I.	1 □ 24a. Was perfo	Yes 2□ No an eutopsy	3 Probably 4 Unkrw  24b. Were autopsy finding available prior to completion of cause
Pert II. Other significant condition  COCAINE USA	AGE		underlying cause g	26. Place of Dec	1 🗆 24a. Was perfo	Yes 2 No	3 Probably 4 Unknown 24b. Were autopsy finding available prior to completion of cause of death?
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Registrar

JAN 0 5 1999



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State of Maryland / Department of Health and Mental Hygiene 9 8 4 1072

			Cei	rtificate of	Death	Re	g. No.	F\$ 1	0 / 2	
1	1. Decedent's Neme (First, Middle, Last	)				2. Date of Deeth	1		3. Time of D	eath
hysician - /Medical	Etta M.	Bohm				December	20, 1	1998 8	8:20 P	.М.
xaminer	4e Facility Nama (If not Institution, giva	street and number)			4b. City, Town, or L	ocation of Death	4c. County			
	960 Stable Ct.				Davidsonv	ille	Anne A	rundel	Ţ	
al or	5. Social Security Number 6. Se	7. Age (In 71 × 71	yrs. last birthday) Yrs.	Months Deys	r If Undar 24 Hrs.		927	9. Birthplac Country North	Carol	Foraign ina
	Usuai Rasidence of Decedant									
	10a. State 10b. County	100	City, Town or Lo	ocation				10d	I. Inside City	
to	Maryland Anne Arun	ndel	Davidsor	nville					1 □ Yes 2	XX
il Director	10e. Street and Number 960 St	able Court		10f. Zip Coda	21035	10	g. Citizan of V US		n	
Funeral	11. Maritei Status	12. Wes Decedent Ever	in U,S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Maxican, Puerto	ecify Yas or No-		e - Amarican		
by Fur	1 Never Married 2 Married 3 ☑ Widowad 4 Divorced	Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Detas:		1 Yes 2 No		Hican, atc.)	Specify	ok, White, etc Whit		
P	15. Decedent's Edu	cation	16a. Dece	dant's Usuel Occi	upation	1	6b. Kind of B	usinass/Indus	stry	
Completed	(Spacify only highast grad	a completed)	(Giva	kind of work don DO NOT usa retir	a during most of work red)	king				- 18
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Be C	17. Father's Nama (First, Middla, Last)		14.7		18. Mothar's Nam	na (First, Middla, M				
0	James Rufus	Furr			Aggi	e Ma	nnor			
-	19a. informant's Neme/Ralationship (T)		19b. Maili	ng Addrass (Stree	et and Number or Ru			State, Zip Co	ode)	
	Wayne Carey/Friend		Sa	me as it	tem 10					
	20a. Mathod of Disposition	2	Ob. Placa of Dispo	osition (Nama of	1	Data 2	Oc. Location -	City or Town	n, Stata	
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	4 ☐ Donetion 5 ☐ Other (Specify)  21. Signatur → Funeral Service Licens		maryland	Neme and Add	n's Cemete	ry 12/23	/98 Ch	eltenh	am, MD	-
once.	21. Signatur Purlarar Sarvice Licaus	/ /	Ğ	eorge P.	ress of Fecility Kalas Fu	neral Hon	ne, P.A			
-	ano yas	10 /)	2	973 Solo	mons Isla	nd Rd., H	Edgewat	er, M	D 2103	7
	23a. Pert1 Entar tha disease or complishock, or heart failure. List only o	lications that causad than no cause on each lina.	daath. Do not an	tar tha moda of dy	ying, such es cardiec	or respiratory arra	st,	ir	oproximate ntarvai Batwe	en en
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9	resulting in daeth) Lest							i		
N.		d						1		
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To Be	25. Was case referred to medical examiner?	Hospital:	оПетіо : : :		Whor	th (Check only one				
-	1 Yes 2 No '	1 LI Inpatient	2 ER/Outpatie	III SEI DOA	4 Li Nursing n	ome 5 Raside 28d. Describe ho				
cation	1 Natural 5 □ Panding	28a. Date of Injury (Month, Day Ye	ar) 280. Time o	W	fork? ☐ Yes 2 ☐ No	Lou. Describe NO	injury occur			
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	1 June	Oten 1	10	D'	38129		DEC ?	21,19	30	STILL!
	30. Neme and eddress of person who co	omplated cause of death	(item 23a) (Type,	Print)						
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State	31. Data filad (Month, Day, Year)	32. Registrar's								
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death Month **Physician** CASSANDRA JOHNSON BROWN 3:25 AM December 1998 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 17003 Village Drive West Upper Marlboro Prince George's 5. Social Security Number if Undar 1 Yaar If Under 24 Hrs. Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Months Days Hours Yrs. 212-68-5725 42 September 28,1956 Washington, DC Director Usuel Residence of Decedant the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show ahow Maryland Prince George's Upper Marlboro 1 ¥ Yes 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with "natural", or items 23s or edical Examiner must be U.S.A. 20772 17003 Village Drive West Funeral filed within 72 hours after death 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 [X] No If Yas, Giva Year or Detes: Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American Indian, Biack, Whita, etc. 11. Marital Status 1 ☐ Never Merried 21 Married Specify: Black Baltimore, Maryland 21215-0020 1 Vas 2 No Specify p 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Private Homemaker 2 years 18. Mothar's Nama (First, Middle, Malden Surname) 17. Fathar's Nama (First, Middla, Last) . Pages 1 and 2 should be filt ment of Health end Mental Hant: If tem 27 is marked oth lury or other traumatic even Be Annie Pelder Ernest N. Johnson 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 17003 Village Drive West, Upper Marlboro, MD 20772 Michael T. Brown/Husband 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 12723 1 Burial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any injury or once. Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 1998 22. Nama and Addrass of Facility
J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses Vercen Va. 100 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical tmmadiata Cause (Finel CAUCER GASTRIC mos disaase or condition resulting in death) Examiner Dua to (or as a consequence of Examiner that the deeth certificate be executed physician end s the buriel-transit Sequentially list conditions, if any, laeding to immediata cause. Entar Underlying Cause (Disaase or injury that initieted avents rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): 80 ettending p signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy periormad? page 2 s ATTYNE STYNE 1 □ Yes 2 □ No certificate Hospital or Attending Physician:
 124 hours after deeth.
 Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Presidence 6 Othar (Specify) 2 1 Yes 2 4No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how Injury occurred Certification: 5 Panding investigation 1 Naturai 1 Yes 2 No 2 Accidant 3 Suicida 6 ☐ Could not be datermined 281. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) illed in by 4 Homicida 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical complately (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 018219 LD Stephen Staal, M.D. 30. Nama and addrass of person who completed cause of death (item 23a) (Type, Print) 1221 WERCHNTICE LAWE LARGO

State Registrar 31. Date filed (Month, Day, Year) 32. Ragistrar's Signetura DEC 2 1 1998



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State of Maryland	Department of Health and Mental Hygiene	1	0	7	

ian			Ce	ertificate of	Death		Reg. No.		
ian i	1. Decedent's Name (First, Middle, Las	st)				2. Data of Da Month		Van	3. Time of Death
cal	William	Bright, J:	r.				ber 16	Yaar 1998	1:46AM
ner	4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Deat			2. (01111
	Prince George's	Hospital Co	enter		Cheve	erlv	Princ	ce Geo:	ree's
	5. Social Security Number 6. S	ex 7. Aga (In	yrs. last birthday	/) If Undar 1 Yas	r If Under 24 I		rth		ca (State or Foreig
	214-34-6151 Usual Residence of Decedent	M 2□F	51 Yrs.	Widning Day	- Hours	March			yland
	10a. Stata 10b. County	100	c. City, Town or I	ocation				100	d. Inside City Limits
Director	Maryland Prince 10e. Street and Number	George's	Ca	pitol He			10g. Citizan of	What Country	1 X Yas 2 □ No
	1213 Dunbar Oa	ks Drive		2	0743		Und	ted Si	tatas
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þ	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas:		1 ☐ Yes 2 ☐ No		uarro Mican, etc.)	Specif	ck, Whita, at b: Blac	
Completed	15. Decedent's Ed	ucetion	16a. Dec	edant's Usual Occ	upation		16b. Kind of B	usiness/Indu	stry
ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Giv life.	e kind of work don DO NOT use retir	e during most of red)	working			
E C	12th	Oollogo (1 401 54)	San	itation	Worker		Dept. c	f Publ	lic Works
Be	17. Father's Nama (First, Middle, Last)				18. Mothar's	Name (First, Middle	, Maiden Sumar	ne)	
10	William Br	ight, Sr.				Mvrt1	e Parrar	1	
	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (Street	et and Number of	Rural Routa Numb	er, City or Town	, State, Zip C	code)
	Mary F. Buck - S	ister	1213	Dunbar	Oaks Dr.	, Capito	l Height	s. MD	20743
	20a. Method of Disposition		Ob. Place of Disc	oosition (Name of ematory or other p		Date	20c. Location		n, Stata
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					10/01/0			
	21. Signature of Funeral Sarvice Licens			Memori 22. Nama and Add		12/21/9			MD
	1 - A	# 7	T I			Stewart 1			
	23a. Part I Enter the disease, or comp	20001			_	l., N.E. 1	-	).C. 20	0019
Examiner	Immediate Cause (Final disaasa or condition rasulting in death)	Due Hypert	to (or as a conse		ase	•		1	
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edical	that initiated events resulting in death) Last	Due	to (or as a conse	quence of):					
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To B	examiner?	Hospital:	2 ER/Outpatie	1 3 DOA 0	thor			or /Conside	
	27. Manner of Death	28a. Data of Injury	28b. Time			g Homa 5 Resi	how injury occur		
5	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Yea	(r) tnjury		onk? ∃Yas 2⊟No				
Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At homa, farm, st			28f. Location ( City or To	Street and Numb wn, State)	per or Rural F	Route Number,
	29a. Certifier (Check only one)  1 □ Certifying Phy 2 □ Medicat Exami	elcian: To the best of my iner: On the basis of axan and mannar stated.	knowledge, deal	th occurred at the threat the threat threat investigation, in my	lime, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and mo	anner as state and dua to th	ed. ne cause(s)
=		and the man stated.		29c Licer	isa number		29d. Data signe	d (Month De	V YAR!
Medical	29b. Signature and titla of certifiar				and the second		and alfile	- property wa	7,
	29b. Signature and titla of certifiar								
	29b. Signature and titla of certifiar	M.D.			D51006		Decemb	er 17,	1998

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Vear MARGRIE JOHNSON BROWN 8:55PM 98 16 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON FORT WASHINGTON TRINCE GEORGES HOSPITAL If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 1□M 2XF Months Days Hours 218-34-6703 76 22,1922 MARYLAND APRIL Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10223 BRIARWOOD PLACE 20601 UNITED STATES 14. Race - American Indian, Black, White, etc. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yas 2 ☐ No if Yes. Give 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3. Widowed 4 □ Divorced BLACK Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 5TH GRADE CUSTODIAN BOARD OF EDUCATION 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) WESLEY JOHNSON ELVIRA STARKS JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 10223 BRIARWOOD PLACE, WALDORF, MARYLAND 2060] ETHEL HOLTON / DAUGHTER 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAK GROVE CHURCH CEMETERY 12/21/98 GRAYTON, MARYLAND 21. Supplier of Funeral Service Licensee 22. Name and Address of Facility HORNTON FUNERAL HOME, P.A. WIA C. THORNTON JOHN M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20640 Approximate Interval Between Onsat and Death Immediate Cause (Final Congestive disaase or condition resulting in death) Due to (or es a consequence oi) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy 1 Vee 2 2No 1 Yes 2 No 25. Was case rafarred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner and burial-tran physician certificate be the 80

**Physician** 

/Medical

Examiner

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Completed

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f shor treumstic event, the Medical Examiner must be notified at

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Department of Health Important: If Item 27

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Maryland 21215-0020

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Records,

Division of Vital

9SM ò the deteched á signed t peeu has page 2 certificate or Attending Physician: efter death. Director: After this certific luneral

Examiner

Physician/Medical þ Completed Be P Certification:

Hospital 24 hours e 24 hours Funeral pletely To the

Medical

1 X Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Kin

6 Could not be determined

29c. License number

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

036562 December 18, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Banton

2. Registrar's

wingston Rd # 208 FORT WASHINGTON, MD

31. Date filed (Month, Dey, Year) State DEC 2-3 1998 Registrar

3 Suicide

29a. Certifier

4 Homlcide

(Check only one)

£ 3 £ \$ 030

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygierie R Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ra1ph Couchman December 28, 1998 11:00 P.M. /Medical 4a Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** Deys 1 XM 2□ F Yrs. Director 90 214-09-9043 Dec 22 1908 West Virginia Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 X No Maryland Washington Hagerstown Direct 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1613 Sherman Avenue 21740 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or he and yiljury or other traumatic event, tra Medical Examina and binds. 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 - 8Expediter Aircraft Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin S. Couchman P Jennie Small 19a. tnformant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Fout - Daughter 7411-C Round Hill Road Frederick, Md. 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 12/31/98 Hagerstown, Maryland 21. Signeture of Funeral-Service Licenses 22. Neme end Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 unne 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner disease Vascular physician end s the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) SE ettending | signed by the el Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown p should I 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? ils certificate hes t director, page 2 s 1 ☐ Yee 2 € No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 V Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

law requires that the deeth certificate be executed P.O. Box 68760 Records, The Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

with the Meryland

death

altimore, Maryland 21215-0020

State Registrar 29b. Signature and title of certifiq

obert Date filed (Month, Day, Year)

scorna 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

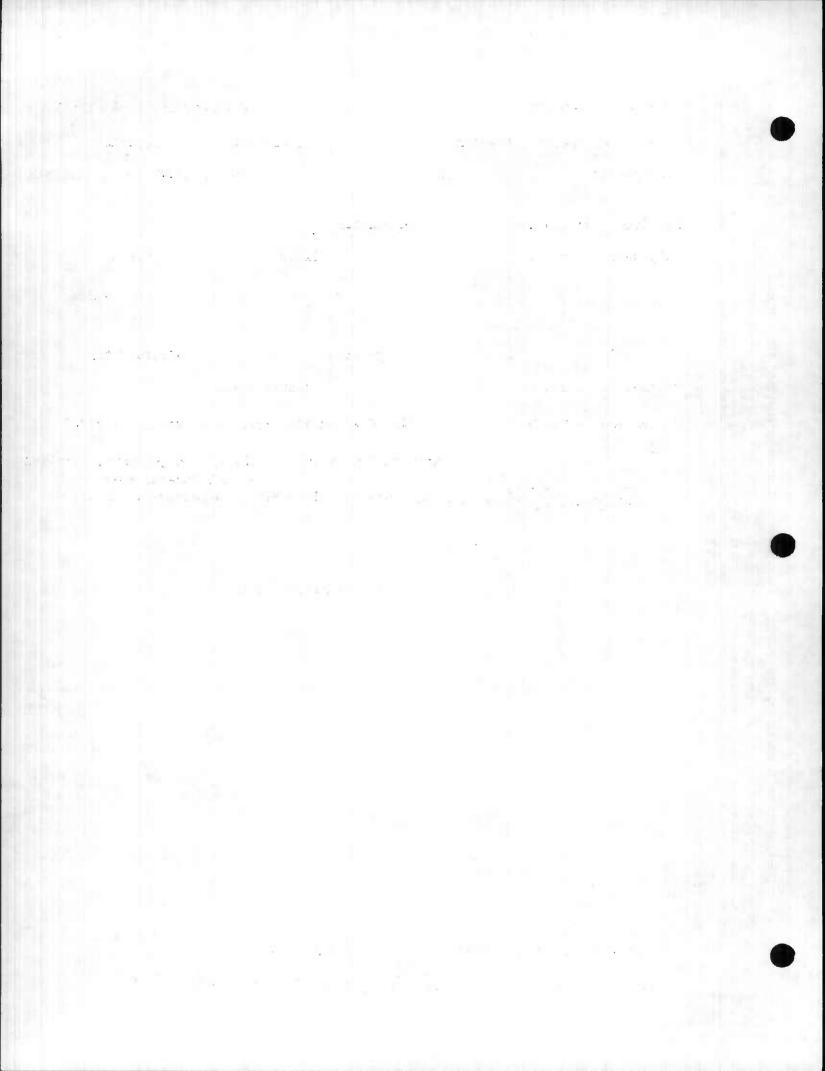
Scouner, M.D.

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32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 98 41077

Dhusia	ion	1. Decedent's Na	me (First, Middle,	, Last)			Tificate	or Deat	n	2. Date of De		Vaca	3. Time of Death
Physic /Medi Exami	ical	MARGA 4a. Facility Name	(If not institution,	give street end n	umborl	STUS		4b. City,	Town, or Le		Day ABER 2 h 4c. Coun	4, 1998 ty of Death	4:27 PN
Funeral		WILLIAM 5. Social Security		RETIRE 6. Sex	MENT 7. Age (In yrs.				UAM er 24 Hrs.	SPORT 8 Date of Bir	WAS	SHIN	
Director		212-38 Usual Residence	3-7636	1□ M 2⊠F	92	Yrs.	Months D	eys Hours	s Min.	8. Dete of Bir (Month, De OCT 7	iy, Year)	Stat	place (State or Foreign http: ELINE, PA
the Maryland 28a-f show	ctor	10a. State	10b. County WASH	INGTON		y, Town or Lo	cation MSPOR	T				1	0d. inside City Limits 12 Yes 2 □ No
th with the 23s or 28s	ai Directo	10e. Street and No		TIZAN	ST		10f. Zip Co		795		10g. Citizen of	What Cour S A	ntry?
5-UUZU 72 hours after dea naturel; or items	by Funerai	11. Marital Status 1 □ Never Mar 3 ₩idowed	ried 2 Marrie	Armed F	2 No live		Was Decedent f Yes, specify I□Yes 2⊠			ecify Yes or No Rican, etc.)		ack, White,	etc.
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be file d other	To Be Co	17. Fether's Name			TRESSI		EMA	18. Moi		e (First, Middle)	, Maiden Suma	me)	
2 E E C F		19a. Informant's N		p (Type, Print)	UGHTER	19b. Meilin		reet and Num	ber or Run	PAR SY	er, City or Tow	n, State, Zip	
mit. Page partment o portant: If y injury or			☐ Cremation 3 5 ☐ Other (Spe			emetery, cren	sition (Name on natory or other VEN (E) . Neme end A	place)	eility m	Date 12/29	HAGER SREVE	STOUN	
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Examiner	lner	disease or condition resulting in death)	on		Due to (or	r as a conseq							DAYS
certificate be axecuted ding physician and se as the burial-transit	cal Examiner	Sequentially list or if any, teading to in cause. Enter Und Cause (Disease or that initieted event	enditions, mmediate erlying r injury s	DYS	PHAGIA EBROV	as a conseq	LAR	Accis	)Ept	•			2 WEEKS
certif nding use a	an/Medical	resulting in death)	Last	a Hyp	ERTER		Jenice Oil						EARS
requires that the death ween signed by the atter hould be datached for r	by Physicia	Part it. Other stgni		contributing to a	death but not resu	Ilting in the ur	derlying caus	e given in Par	t t.	12.22	tobacco use c Yes 2□ No	ontribute to	the cause of death?
2 s	Completed t									24a. Was perfo	an autopsy med?	001	ere autopsy findings elleble prior to empletion of cause deeth?
F # 6	Be Com	25. Was case reference	rred to medical					28. Pia	ce of Death	1 🗆 t		10	Yes 2 No
ng Phys fter this uneral di	2	1 Yes 222 27. Menner of Deat 1 Xeturat 2 Accident		28a. Date (Mor		ER/Outpetlent 28b. Time of tnjury	28c.	Other:  injury at Work?  1 Yes 2		me 5 Resid 28d. Describe I			()
tal or Attending in a star death.  el Director: After led in by the fune.	Certification:	3 Suicide 4 Homicide	6 Could no determine	ed 289. Place	e of tnjury - At holing, etc. (Specify	me, farm, stre	et, fectory, of	ice		28f. Location (5 City or Tox		ber or Rura	Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Medical	29e. Certifier (Check only one)	2   Medical Ex	Physician: To the aminer: On the b and man	best of my know easis of examinati ener steted.	vledge, death ion and/or inv	estigation, in r	ny opinion, de	eath occurr	and due to the e	cause(a) and m date and ptece	anner as st , and due to	ated. the cause(s)
To with To con		29b. Signature and		<u></u>	TARE PHY	BICIAN		t204			29d. Dete signi		
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Sta Registr		31. Date filed (Mon	EC 28	1998	Registrar's Signate	ure $\beta$ .	ppa	Ks/					

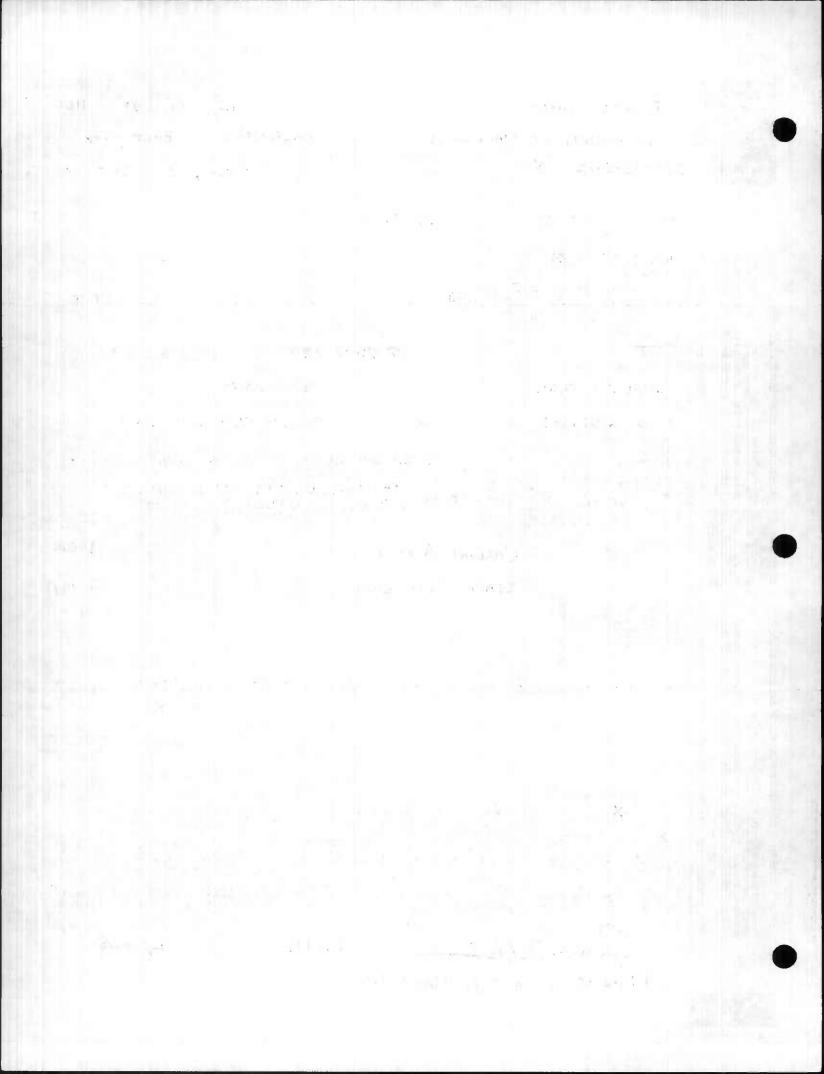
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Veer **Physician** Kobert CATON 12 98 1100 01 \* /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND BALT. CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 12M 20 F Months 232-32-5412 Hours 69 NOV. 13, 1929 WEST VIRGINIA Director Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BERKELEY MARTINSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? RT. 1, BOX 179M 25401 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces?

1. XYes 2 □ No If Yes, Give 1948 — Yeer or Detes: 1952 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status permit. Pages 1 end 2 should be filed within 72 hours efter or Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flen any injury or other traumatic event. Bleck, White, etc. 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 INVENTORY CLERK AT&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 CHARLES B. CATON MARY KOONTZ 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) HELEN CATON/WIFE RT. 1, BOX 179M, MARTINSBURG, WV 25401 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV 4 ☐ Donetion 5 ☐ Other (Specify) ROSEDALE CEMETERY 12/4/98 21. Signeture of Funeral Servica Licensee 22. Name end Address of Facility BROWN FUNERAL HOME, 327 W. KING STREET 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final 1 HOUR CARDIAC ARREST disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner SEPTICEMIA 7 days STAPH physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): certificate be execu Box 68760 Physician/Medical Due to (or es e consequenca of): 88 188 50 ed by the e Pert II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? Completed peeu 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this funeral 27. Menner of Death 1 B Natural 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After Attending 5 Pending 1 Yes 2 No death. investigation 2 Accident Hospital or Attend 24 hours after death Funeral Director: A 6 ☐ Could not be 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier edical (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fille of cartifier 12/28/98 P11411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALOSSI OF MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 4 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene R Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3 Time of Death Month Robert 1998 COFFIN DECEMBER 27 10:45 AM 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Berlin Nursing and Rehabilitation Center | Berlin | Berli Worcester Birthplece (State or Foreign Country) 5. Sociel Security Number 11XM 2□ F Yrs. 220-01-9738 81 Nov. 25, 1917 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Worcester Ocean City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10128 Silver Point Lane 11. Meritei Stefus 1 Never Married 2 Married 12. Wes Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 12. Wes Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married If Yes, Give Yeer or Detes: Korea 21842 US Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Yes 2 XNo Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Drug Store Co-Owner 11 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Suma Clinton Coffin Sarah Massey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10128 Silver Point Lane, Ocean City, Md. 21842 Evelyn Coffin (wife) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 X Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete **Evergreen Cemetery** 4 □ Donetion 5 □ Other (Specify) 12-30-98 Berlin, Maryland 21. Signa je of Fuyeral prvice icansee 22. Name end Address of Fecility The Burbage Funeral Home, 23a. Fert. Enter in discers or complice on sthet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hand failure. List only one series on each line. Approximate Intervai Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in death) Obstruitive Buling Bisen yos Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Pert il. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Handlerin - Athophice 1 + Kidner 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to Cnpc/ n+nin/ Fisiky lasin

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

P

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified. Brother

physician a s the bunalsigned by the a certificate has b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner Physician/Medicai à Completed Be Certification: To

edical

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

completion of cause of death?

1 ☐ Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? 1 Yes 2 No

 Location (Street end Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and itle of certifier

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical examiner?

27. Menner of Deeth

1 Neturei

2 Accident 3 Suicide

4 Homicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

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30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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FEDERICO G. ARTHES

46 TEAL CIRCLE OCEAN PINES MD 21811 410-641-4400

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28a. Dete of Injury (Month, Dey Year)

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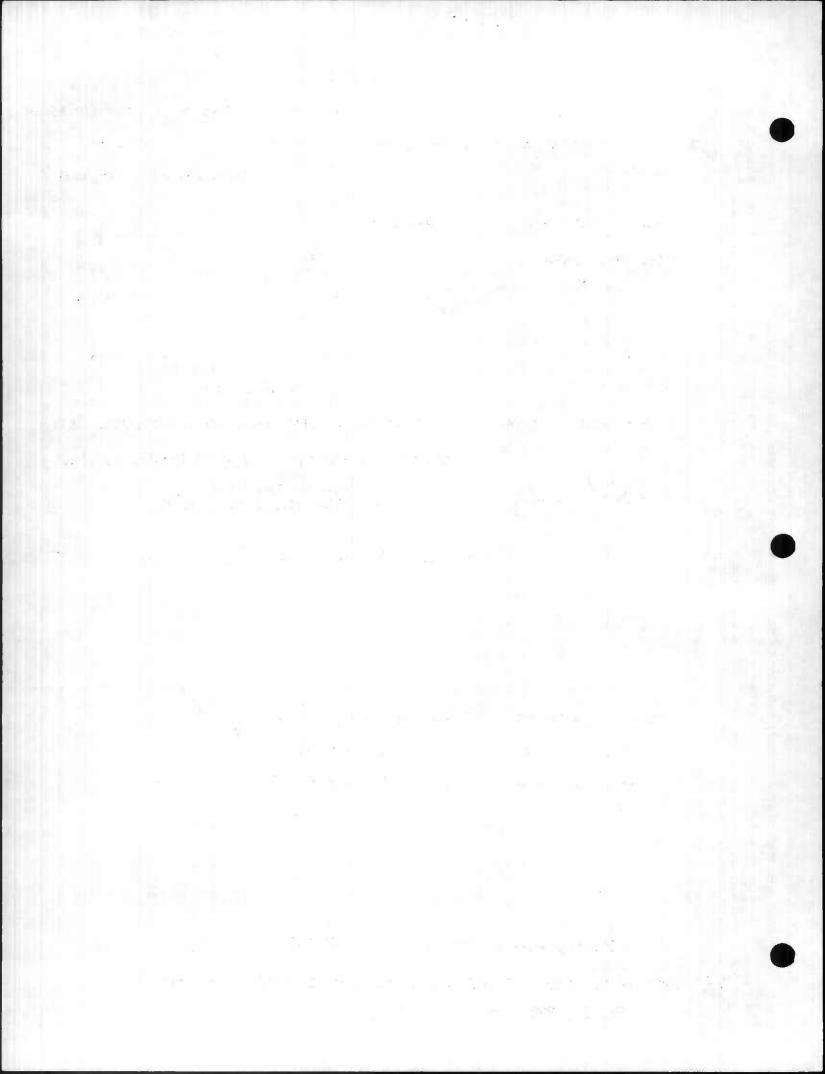
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28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

To the Hospital or within 24 hours aft To the Funeral DI completely lilled in



Division of Vital Records, P.O. Box 68760, that the death certificate be or Attending Hospital

Funeral

**Director** 

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Pages 1 and 2 should be fill ment of Health and Mental Hisant: If them 27 is marked oth

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Department o Important: If any injury or injury or

**Physician** /Medical

**Examiner** 

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Baltimore,

State Registrar 31. Dete filed (Month, Day, Year)

HYON SEO

29b. Signature and titla of certifier

4940 Eastern 32. Registrar's Signatura

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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29c. Licansa number

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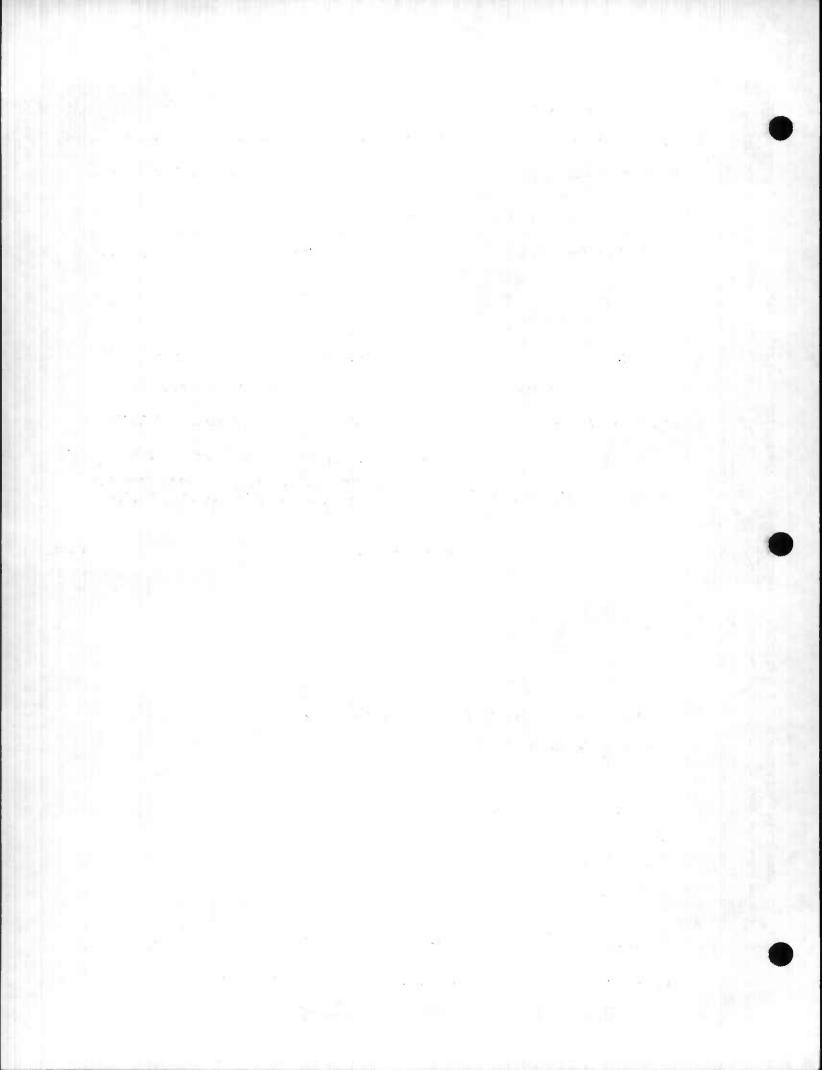
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29d. Dete signad (Month, Day, Year)

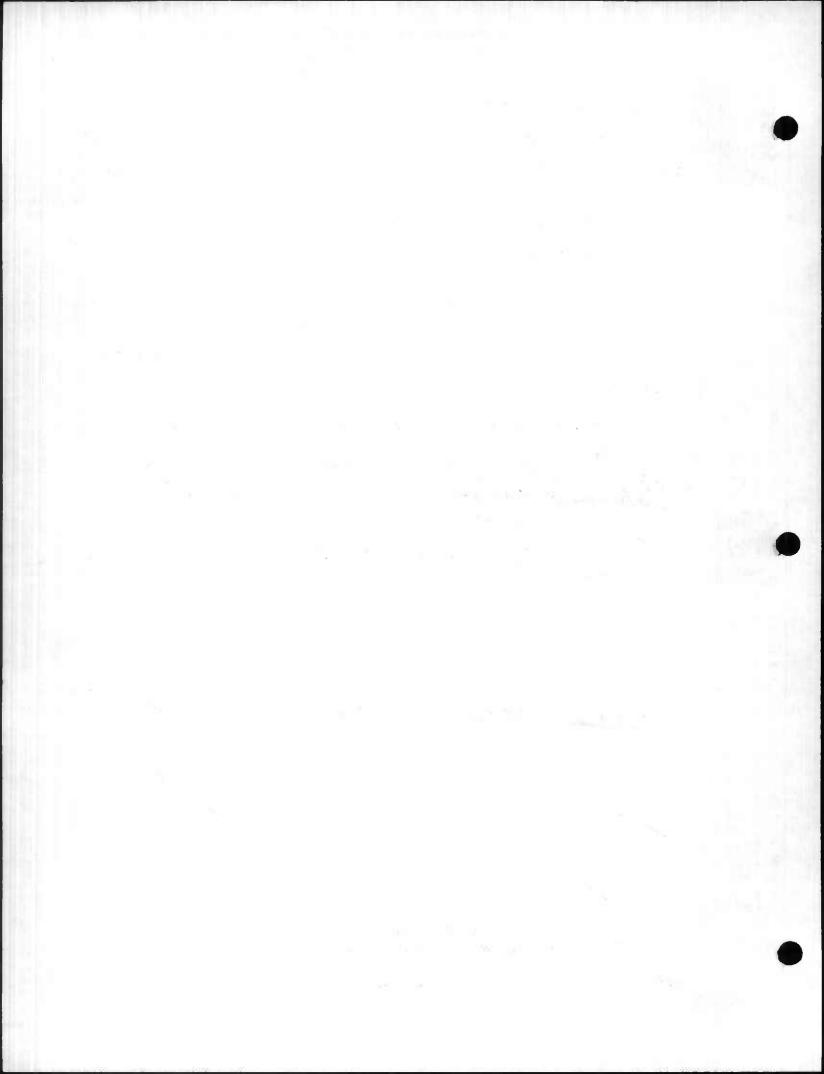
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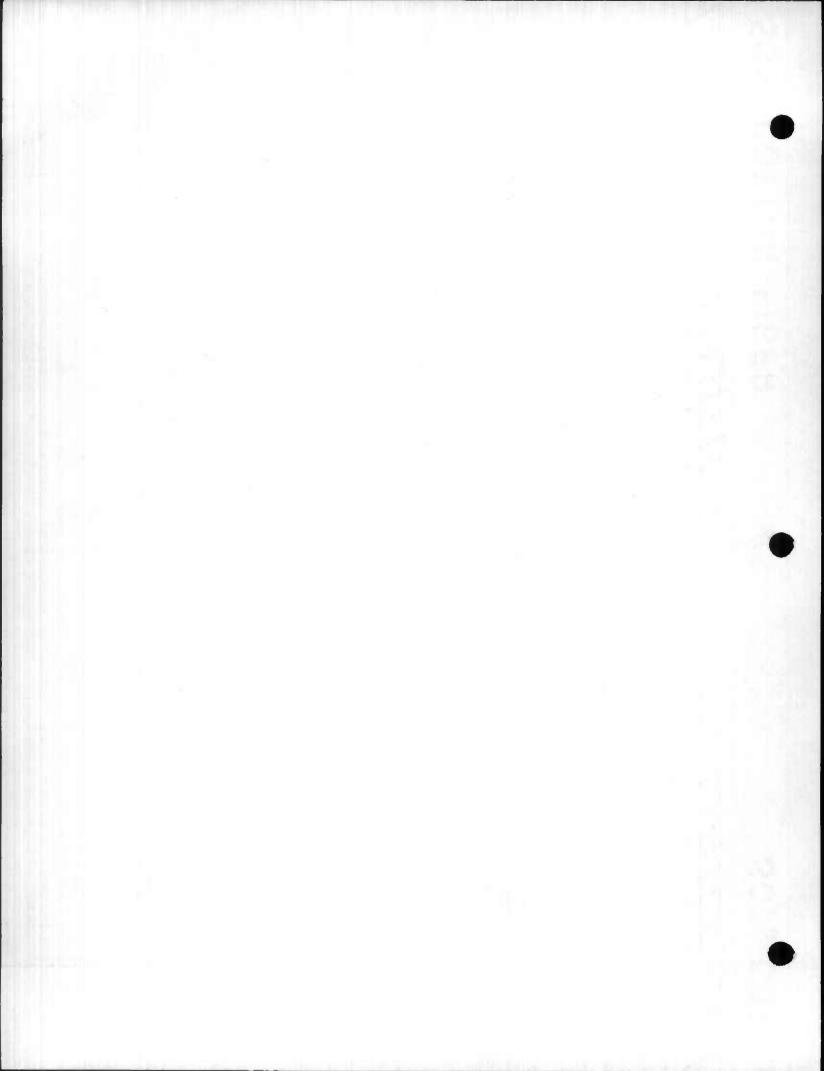
State of Maryland / Department of Health and Mental Hygiene 98 11 108

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Physicia	an	1. Decedent's Nama (First, George J	Middla, Li oseph						2. Deta of Dea Decembe	Dayo	Yaar	3. Tima of Death
/Medic Examin		4e. Facility Nama (If not Ins	titution, gi	ve street and numbar	)			4b. City, Town, or I		4c. Count	1998 y of Deeth Freder	4:37AM
Funeral Director		5. Social Security Number 577–38–7136 Usuel Rasidanca of Dacad	6. s	170	8		If Under 1 Yeer Months Days	If Undar 24 Hrs.		, Year)	9. Birthp	ieca (Stata or Foreig try) ington DC
the Maryler 28a-f show	_	10a. Stata 10b. 0	,			, Town or Lo					1	0d. Inside City Limit
Ne M	ecto		ederi	ick	N	ew Wir						1 □ Yas 2 ☒N
23a or 2	Funeral Director	10e. Street and Number 9820 Parsona	ge La	ane			10f. Zip Coda 21776	5	1	U.S.A.		try?
n 72 hours after deeth with the Marylend "natural", or frems 23s or 28s-f show colcal Examinet must be notified at	þ	11. Marital Stetus  1 Never Married 28 3 Widowad 4 Dh		12. Was Decedant Armed Forces' 1 ☑ Yes 2 ☐ If Yes, Giva Yaar or Datas:	No No	'	Nas Decedant of f Yes, specify Cut I ☐ Yes 2 🔯 No	Hispanic Origin? (Speen, Mexican, Puerto o Specify:	pecify Yes or No- Rican, atc.)		ce - Amaric ick, Whita, if fy: Wh	
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0000		19a. Informant's Name/Re		***				t and Number or Ru				
other tra		Myrtle W. C	arli	n - wife	001 51			ge Lane, l				
8== 6		20a. Method of Disposition  1  Burial 2 □ Crem  4 □ Donation 5 □ Ot					sition (Nama of natory or other pla 's Cemet	1.	Dec. 21	20c. Location Liberty		
permit. Page Department of Important: If any injury or once.		21. Signature of Funarel Si	rvice Lice	nse Lard	Der	22	. Nama and Addr	and of Equilibr	artzler			
		23e. Pert1. Entar tha disas shock, or haart feilure	sa, or com	plications that cause	d tha daath.							Approximata Intarvsi Batween
Physician /Medical Examiner	iner	Immediata Cause (Final disease or condition rasulting in death)		a. CARC		es a consaq		PROSTA	TE			8 years
icete be executed physician end s the buriel-transit	ai Examiner	Sequentially list conditions if eny, laading to immadiate causa. Entar Undarlying Causa (DIsaasa or Injury that initiated events	ĺ	c		es a conseq						
in e in	n/Medical	rasulting in daeth) Last	ι	d	Due to (or	as a conseq	uence of):				İ	
death ce e ettendi	Cla	Pert il. Other algnificant co	nditions o	ontributing to death h	uit not recui	ting in the ur	dedylaa causa a	iven in Dart I	22h Did to	hearn use or	antributa to	the cause of desth
that the ed by th detach	Physician/	COLONA	الع	ALXO	27	-	EASE		1 🗆 Y			pably 4 Unknow
8 54	Completed by								24a. Was a perfor		SVS	ara sutopsy findings bilabla prior to applation of causa daath?
The lay	E								1 🗆 Y	es 2 No	1□	Yes 2□No
certificate rector, pag	Re	25. Was case referred to m	edical					28. Place of Dee	th (Check only or			
000	0	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatio	ent 2 E	R/Outpatien	t 3□ DOA Ot	h	oma 5 Reside		har (Specify	<i>(</i> )
Attending Ph ir death. ector: After th by the funeral			anding ivastigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Inju		28d. Dascribe he			
or Attendi after death Director: A d in by the f	Certification:		ould not b atamined	28a. Place of In	ury - At hon c. (Specify)		et, factory, office		28f. Location (Si City or Town		ber or Rura	Routa Number,
4 hou funer tely fill	edicai	29a. Certifiar (Check only one)	rtifying Ph dicai Exsn	ysician: To the best niner: On the besis o and manner st	t examinatio	ledge, deeth on and/or inv	occurrad at the ti astigation, in my	ime, data and placa, opinion, daath occur	and dua to the cared at the time, d	ause(s) and m ata end plece,	snnar ss st and due to	sted. tha cause(s)
To the in within 2 To the complete		29b. Signature end title of c	ertifier 2 4		FTTEN	DNG	29c. Licen	se number	2	9d. Data signe	ed (Month, L 3 / 9 8	
State		30. Nama and eddrass of portion of portion of portion of the control of the contr	. Ru		904	WAST	Print) HWG-70W	RD WE	STANST	er M	12	1157
Registra	9		221	. /	epera	1 19	· Spar	KN				



TAINT NECONDS, T.C. BOX 13149, BALLIMONE, MANILAND ZIZOS-5140	NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal.	ed, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, F.O. BOA IS	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exec	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be find within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumat

	FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTA	L HYGIENI			
	1. DECEDENT'S NAME (First, Middle, Lest) Thomas Parrian (	Cooksey				MONT	OF DEATH	ኃ, 19 <sup>8</sup>		6:20 A M
	4. SOCIAL SECURITY NUMBER 216-44-7090	1 🔀 M 2 🗆 F	n yrs. lest birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Nov.	of Birth h, Day, Ybar) 8, 19	10 M	ary1	
TOR	96. FACILITY NAME (If not institution, give at St. Mary's Nursil RESIDENCE OF DECEDENT				on Location of D			St. M		
FUNERAL DIRECTOR		Mary's		, TOWN OR LOCA Aptico	ATION					I. INSIDE CITY LIMITS? VES 2 NO
IERAL	P. O. Box 572			1	20621			USA	OF WHAT	COUNTRY?
ВУ	11. MARITAL STATUS 1  Never Merried 2  Merried 3  Widowed 4  Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, s	CENDENT OF HISPA pecity, Cuben, Mexico S 2 NO Specia	an, Puerto I		or No 14.	Black, Wi	American Indian, lite, etc. White
BE COMPLETED	18. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT use Steamf	rork done during n e retired.)	ION lost of working		ederal			it
S	17. FATNER'S NAME (First, Middle, Last)	ooksov			18. MOTHER'S NA			Surname)		
	Thomas Vivian C	ooksey	105 MAILING	ADDRESS (Street	LUCY J.			Dieta Tie Ca	dat	
10	Kay Jones - Daug		P. 0.	Box 57	2, Chapt	ico,	MD 206	21		
	1 XBuriel 2 Cremation 3 Remo	S S	t. Charl	es Ceme				iont,		in Head, MI
	John P. Knis			Huntt	Funeral Box 156	Home			504=0	156
	IMMEDIATE CAUSE (Final	List only one cause on a	ich line.			ch aa can	diac or respi	ratory arrest		Approximate Interval Between Onset and Death
	reaulting in death)	. Intra e	CONSEQUENCE OF	): 	ed					about Tweet
NOI	Sequentially list conditions, if any, leading to immediate	Multip DUE TO (OT BUD	CONSEQUENCE OF	eloma						
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	CDUE TO (OR AS A	CONSEQUENCE OF	<b>ን</b> ፡						
		d								
PHYSICIAN: MEDICAL	Dementia	a contributing to death b	ut not resulting i	n the underlyi	ng cause given in	Part I.	24a. WAS AN PERFOR 1 Tes 2	MED?	AW CO OF	RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
N.										
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	ettent a Dos	OTHER:	PLACE OF DEATH (C					
HYS	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. II	me 5 Residence		SCRIBE HOW II	NJURY OCCUR	ED	
ВУ Р	1 0 Natural 5 Pending 2 Accident Investigation	(MOTER, Day, roar)	INJ		YES 2 NO					
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	At home, farm, s	street, factory, off	ice	28f. LOC City	CATION (Street a or Town, State)	nd Number or	Rural Route	Number,
COMPLETED	anal	ICIAN: To the best of my know							nuse(s) sn	d menner as stated.
8	296. SIGNATURE AND TITLE OF CERTIFIES	Dr. M. A. R.			29c. LICENSE NU D 500			29d. DATE 8	28	1998
5	30. NAME AND ADDRES OF PERSON WH Dr. M. A. Rahman				ltown, MI	206	50			
	31. DATE FILED (Month, Day, Year) DEC 3 1 1998	32. REGISTRAR'S SIGN	ATURE B.	Goods.						

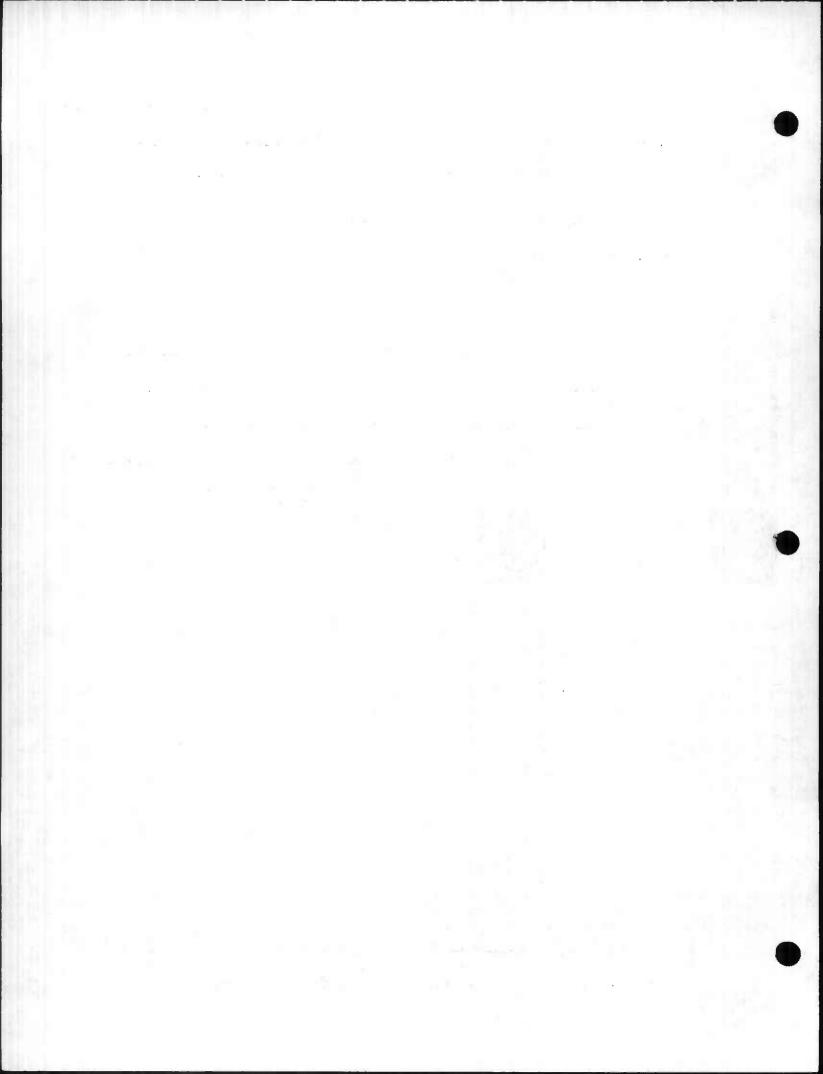


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dec 25, **Physician** <sup>Day</sup> 1998 2:50 pm JOSEPH MARCO CORNACHIA /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 309 S. CEDAR STREET CUMBERLAND ALLEGANY If Under 1 Yeer If Under 24 Hrs. Dete of Birth (Month, Day, Yea Jun 30, 5. Sociei Security Number Birthpiece (State or Foreign Country)
 MD 7. Age (In yrs. lest birthdey) **Funeral** Deys Hours Year) 1 MM 2□ F Yrs 1950 48 Director 215-56-7748 Usuei Residence of Decedent the Marylend 10b. County 10e Stete 10c. City, Town or Location 10d. inside City Limits 28a-f show must be notified at 1 XYes 2 No Director Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 **Нета** 23a 309 S. Cedar Street USA 21502 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American indien, Bieck, White, etc. ified within 72 hours after de I Hygiene. other than "natural", or item raumatic event, the Medical Examiner. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☒ Divorced white Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CSXT Corporation Electrician 12 other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumerne) it and 2 should be fill Health and Mentel H tem 27 Is marked ott Be Frank Cornachia Mary Alice (McDonald) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 s Department of Health ar important: if item 27 is any injury or other trau Tammy R. Cornachia-daughter P.O. Box 354; Wiley Ford, WV 26767 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete Dete 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery Cumberland, MD 12/29 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21502 Cumberland, MD a 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset and Deeth Physician immediete Cause (Finei diseese or condition resulting in deeth) /Medical Uk yrs. Alcohol Abuse Syndrome w/ complications Examiner Due to (or es a consequence of): Physician/Medical Examiner physician and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence off. Box 68760. Due to (or as a consequence of): 85 attending p deteched Division of Vital Records, P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ģ The lew requires 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? page 2 s certificate has 2 0 No 1 Tyes 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical exeminer?
Yes 2 No Be 28. Place of Death (Check only one) Hospitei: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home Certification: To 5 Residence 6 Other (Specify) After this 28a. Dete of injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred or Attending 1 Accident 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No after deetl 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner es stated.

On the basis of examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. To the Hosp within 24 hos To the Fune completely fi (Check only onel 29b. Signeture end this of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) n 10 30. Name end eddress of person who completed cause of death (item 23a) (Type, Print) ne 124 W. Third Street; Cumberland, MD Dr. Paul Snow; 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State DEC 2 9 1998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 17, 1998 December 1:45 PM MARY FRANCES CUFF /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY if Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1□ M 2X F Vrs Director 62 212-80-3651 May 21, 1936 Usuel Residença of Decedent death with the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show trsumatic event, the Medical Examiner must be notified at No Yes 2□ No Director Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10102 Country Club Road 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health end Mental Hygiene. Important: if itsm 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Fran Bleck, White, etc. 1X Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify. à 3 Widowed 4 Divorced Year or Detes: white Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Martin D. Cuff 2 Helen Cecil 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 309 Woodland Way; Romney, WV Paula O'Brien--sister 26757 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 12/21 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one or use on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel e. Anoxic encephalopathy 9 days diseese or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner Aspiration syndrome 9 days that the death certificate be executed physician and is the bunel-trans Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es a consequenca of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attanding p been signed by the a should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Seizures of Vital Records, 2 The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy Completed , page 2 I Ven DON'S 1 ☐ Yes 2 ☐ No certificata or Attending Physicisn: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how Injury occurred Certification: Division After 5 Pending Investigation 1 Netural aftar death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) In by 4 Homicide Dellit 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely ti (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD December 1875 D23334 1998 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND MD

32 Registrer's Signeture

State Registrar

MIS

DINESH SHAH, M.D.,

DEC 2 1 1998

31. Dete tiled (Month, Dey, Year)

DHMH 16 Rev 6/95

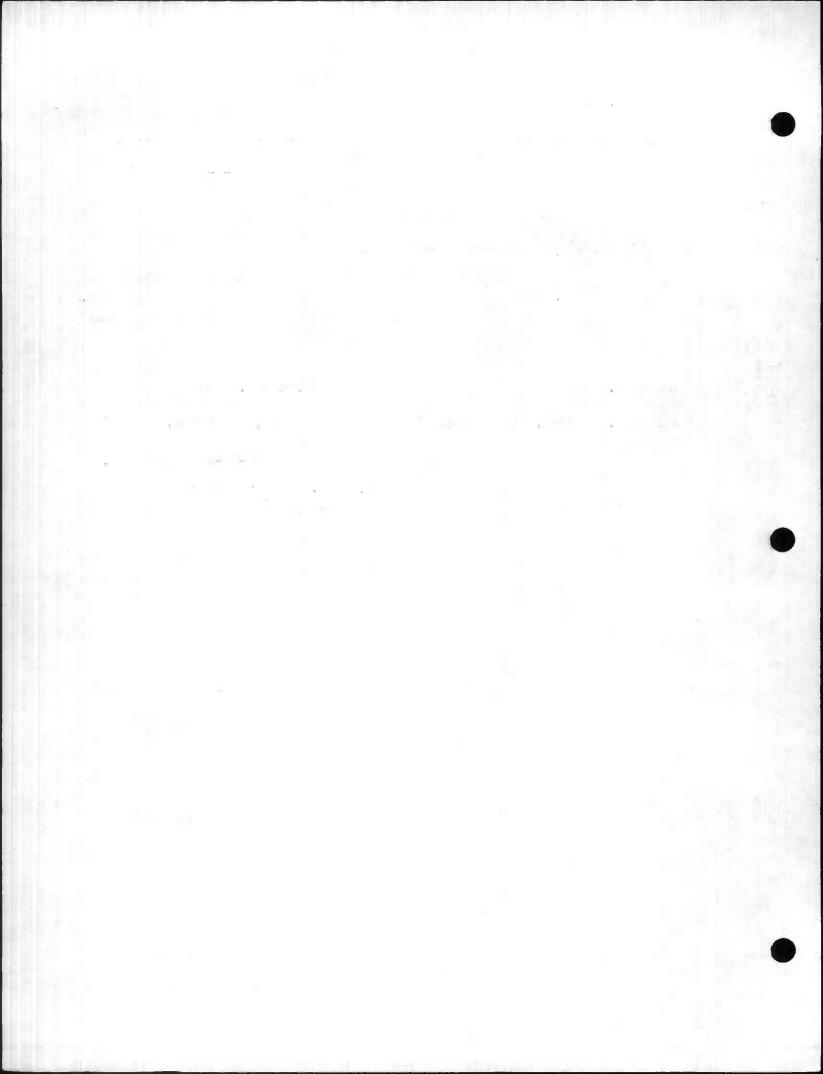
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Amended # 14 718 S, Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q 8

ian	1. Decedent's Neme (First, Middle, La.	et)					2. Date of De Month	Day	Year	3. Time of Deat
cal	HAZEL B. COMBS						DECEMBE	R 18 1	998	8:10 PM
ner	4e Facility Nema (If not institution, give						cation of Deati			
	Sacred Heart Hos	-		hirthday) If Under		berland		Alleg		10
	5. Social Security Number 6. S 236 36 2132	ox 2∑F 89	e (In yrs. last i	Yrs. Months		urs Min.	8. Date of Bir (Month, Da 12-2-0)	y, Year)	9. Birthpli Count	ace (Stata or Formy)
	10a. State 10b. County		10c. City, To	own or Location					10	ld. Inside City Lin
10	MD Allegany	7	Frost	burg						NOXYas 2□
rec	10e. Street and Number			10f. Zio	Code			10g. Citizen of V	Vhat Count	ry?
Funeral Director	Frostburg Villag	ge Nursing	Cente	r 215	32			USA		
ner	11. Marital Status	12. Was Decedent I Armed Forces?	Evar in U,S.	13. Was Deced		ic Origin? (Sp	ecify Yes or No	- 14. Rac	e - America k, Whita, a	
2	1X Never Merried 2 Married 3 Widowed 4 Divorced	1 Yas 2X N If Yes, Give Yaar or Datas:	40	1 Tes		ecity:	ricari, atc.)	Specify		rie White
2	15. Decedent's Ed (Specify only highest gra	ucation	16	Sa. Decedent's Usue (Give kind of wo	Occupation	most of work	ina	16b. Kind of Bu	usiness/Ind	ustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT us	se retired)	most of work	· · ·			
5	unknown			None				Disabl		
90	17. Father'a Name (First, Middle, Last)							, Meiden Suman	10)	
0	Jonas L. Combs						E. Bean			
59	19a. Informant's Name/Relationship (		- 10	9b. Meiling Address						
П	Linda M. Winters  20a. Method of Disposition	s, Great n		16009 Wat		Koad,	Date	VA 20c. Location -		
	XXBurial 2 Cremation 3		ceme	tery, crematory or o	ther place)	1				
	4 □ Donation 5 □ Other (Specify 21. Signature of Europa Service Licen		Port	er Cemete	ry d Address of F	-	2-22-98	Hyndmar	ı KD,	PA
	21. Signature of parties at the color		1///				Funer	al Home		
_	2 / logel	10/16	A STATE OF	Hynd	man. P.	A 155	545			Approximete
	23a. Part1. Enter the disease, or companies shock, or hear failura. List only	one ceuse on each lin	10.	o not enter the mod	e or dying, suc	AT 95 CATORIC (	и гевриетоту а	11621,		Interval Between Onset and Deeth
	Immediate Cause (Finet	e*		100-	-	. 1.1.47	A			10. 11 20
	disease or condition resulting in daeth)			a consequence of):	UCILVI	E LIMO	SILLAR	R	H	Bour luy
			Due to (or as	a consequence or).					91	
	Sequentially list conditions.	b	Dua to (or as	a consequence of):						
	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury								i	
5	that initiated events	C	Due to (or es	a consequance of):						
5 I	rasulting in death) Last									
_	rasulting in death) Last	d								
_	rasulting in death) Last	d								
= 1	Pert II. Other significant conditions of		ut not resulting	g in the underlying c	ausa given in I	Part I.	23b. Did	tobacco use co	ntribute to	the cause of de
rilyaiciairm	Pert II. Other significant conditions of	entributing to death bu						tobacco use co Yes 2□ No		the cause of deal
Dy Physician/M	Pert II. Other significant conditions of	entributing to death bu						Yes 2□ No	3 Prob	ably 45-Unio
by Physician/M	Pert II. Other significant conditions of	entributing to death bu							3 Prob	re autopsy findin ilable prior to appletion of cause
Dy rillysicialism	Pert II. Other significant conditions of CORONARY  CONURCY IVE	entributing to death but					24a. Was perfo	Yes 2 No an autopsy ormed?	3 Prob	re autopsy findin- ilable prior to npletion of cause leath?
completed by Physicianym	Pert II. Other significant conditions of Cornery  Cornery  Cornery  Cornery  Cornery  Corner Remi	entributing to death bu			NEVE ?	MBUIS	24a. Was perfe	Yes 2 No an autopsy med?  Yes 2 No	3 Prob	re autopsy findin ilable prior to appletion of cause
o be completed by Physician/M	Pert II. Other significant conditions of CORONARY  CONURCY IVE	APPENY L	parlu	E RE DIA	26.	MBU (	24a. Was perfo	Yes 2 No an autopsy med?  Yes 2 No one)	3 Prob	re autopsy findin ilable prior to noletion of cause leath?  Yes 2 \( \) No
married of the posterior of the	Pert II. Other significant conditions of CORONARY  CONUNCY  CONUNC	PARAM Hospital: 1 Mapatie 28a. Data of Injur	PALLU.	COutpatient 3 DO	26. A Other: 4	MBU(∫	24a. Was perfe	Yes 2 No an autopsy med?  Yes 2 No	24b. We ava con of d	re autopsy findin ilable prior to noletion of cause leath?  Yes 2 \( \) No
	Pert II. Other significant conditions of CONDANY  CONDANY  CONDANY  CONDANY  CONDANY  25. Was case referred to medical examiner?  1 Yes 2 No  27. Mannar of Death  1 Shetural 5 Pending invastigation	ANERY L  ANERY L  ANERY L  Hospital: 1 Anpatie  28a. Data of Injur (Month, De)	PALLU.	COutpatient 3 DO	26.	MBU(∫	24a. Was perfe	Yes 2 No an autopsy med?  Yes 2 No one) dence 6 Oth	24b. We ava con of d	re autopsy findin ilable prior to noletion of cause leath?  Yes 2 \( \) No
and the second s	Pert II. Other significant conditions of CONDANY  CONDANY  CONDANY  CONDANY  CONDANY  25. Was case referred to medical examiner? 1   Yes 2   No  27. Mannar of Death 1   Netural   5   Pending	PATELLINE Hospital: 1 Ahpatie 28a. Data of Injur (Month, De)	PALLUL  nt 2 ER/(  Year) 28b	Outpatient 3 DC	26. A Other: 4 8c. Injury et Work? 1 □ Yes	Place of Deat	24a. Was perfo	Yes 2 No  an autopsymmed?  Yes 2 No  one)  dence 6 Oth how injury occur  Street and Numb	3 Prob  24b. We ava con cold  1 Let (Specify red	ably 4 Unitroperation of cause leath?
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 8 4 1086

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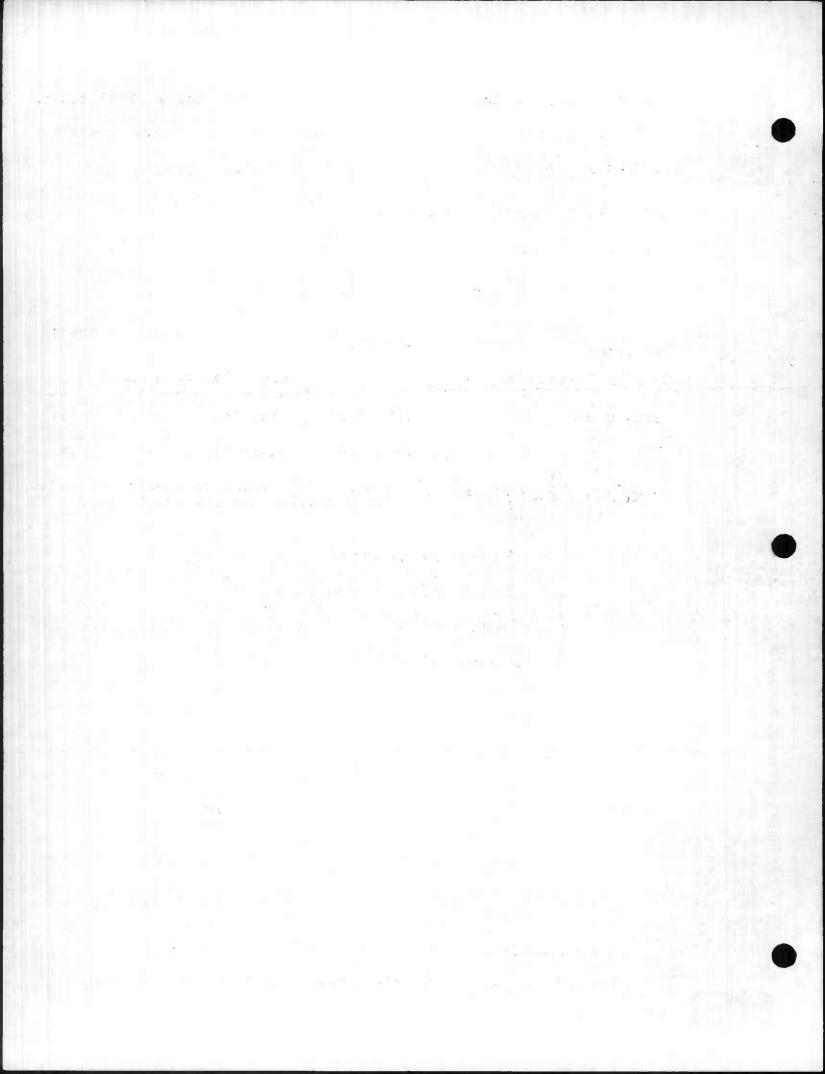
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State of Maryland / Department of Health and Mental Hygiene 8

Certificate of Death

					OCIT	meate of	Doutin		Heg. No.		
Physic /Medi		1. Decedent's Name (First, Middle, La Samuel Eugen	•	r				2. Date of De Decemb	perDay24,	1 <sup>Y</sup> 9 <sup>*</sup> 98	3. Time of Death 3:30pm
Exami		4s Facility Name (If not institution, giv 1079 Magothy	e street and numbe VieW	er)			4b. City, Town, or Annapol			of Death Arur	ndel
Funeral Director		5. Social Security Number 6. S 21 9 – 20 – 38 3 3	ex 7.	Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days			th ay, Year) 8,1928	9. Birthpla Country MD	ce (State or Foreign v)
D		Usuel Residence of Decedent									
Merylan a-f ehow	tor	MD 10b. County Anne A	rundel	10c. City, Tow Anna						100	f. Inside City Limits 1 ☐ Yes 2 ☐ No
N with the	al Director	10e. Street and Number 1079 Magothy	View			10f. Zip Code 214(	01		10g. Citizen of U.S		y?
72 hours effer deeth with the Meryland "natural", or flems 23a or 28a-f ehow colcal Experient the rectried at	by Funeral	11. Maritel Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decede Armed Force 1  Yes 2 If Yes, Give Yeer or Date	s? XNo		/as Decedent of l Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Rec Bla Specif	ce - American ck, Whita, et y: Whi	c.
2 ho	8	15. Decedant's Ed		168	. Decede	ent's Usual Occu	pation		16b. Kind of B	usiness/Indu	stry
within ane. then "	Completed	(Specify only highest grade) Elementary/Secondary (0-12) 8th grade	Collage (1-4c	or 5+)	(Give k Jife. D Sup	ind of work done O NOT use retire ETV1SO	during most of word	king	Resea	rch c	company
be file itel Hy d othe	To Be C	17. Father's Name (First, Middle, Last) Charles Russe	ll Deck	er			18. Mother's Nar Mary		Ruth S		
nd 2 should be sith and Mante 27 is marked r traumatic er	-	19a. informant's Name/Relationship ( Betty Decker	Type, Print)	19			tand Number or Au thy View				
permit. Peges 1 end 2 should Department of Health end Mer Important: if item 27 is merke any injury or other traumatic once.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremetion 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)		cemete	mera vo	ition (Name of atory or other pla Wn Cem	December	Date 29,1	20c. Location 998 Bi		
th certificete be executed  Medical Examiner  founding physician and phy	an/Medical Examiner	23a. Part1. Inter the briese, or com ahock, or haart failure. List only  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Dua to (or as a hence (Due to (or as a Due to (or es e	consequ	Jance of):  John My  Jence of):  Jence of):	lopathy	c or respiratory e	errest,		Approximate nterval Between Onset and Death
the deeth y the atter	Sich	Part ii. Other significant conditions of	ontributing to death	h but not resulting	In the un	derlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to t	the cause of deeth?
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delan: The	Be	25. Was case referred to medical					26. Place of De	ath (Check only	one)		
Physician: this certific ral director,	0	examiner? 1 Yes 2 No	Hospital:	atient 2 ER/O	utpatient	3□ DOA O	ther: 4 Nursing H	lome 5 Pres	Idence 6 Oti	ner (Specify)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, it	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		Time of Injury	28c. Inju		-	how injury occu		
or Atters after design of in by the	Certification:	3 Sulcide 6 Could not b determined	28e. Place of	Injury - At home, f etc. (Specify)	arm, stre	et, fectory, office			(Street and Num own, State)	ber or Rural	Route Number,
To the Hospital or within 24 hours aft To the Funeral Dir completely filled in	edical C			s of axamination at			ime, date and place opinion, death occu				
Vithir To the	Me	29b. Signature and title of certifiar				29c. Licen	ise number		29d. Date signe	ed (Month, D	ay, Year)
->-0		J.Som	allion	~		1030	M		12 2	7 95	
		30. Name and address of person who	complated cause of	of death (Item 23a)	(Type, F	rint)	uy, Se	v. PK.	e am	114	0

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 4 088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yesr 12 1998 Patricia Lee Dennis 22 7:40 AM 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 231 Canal Park Drive Wicomico Salisbury 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1 M 2 KF Yrs. 56 1/13/1942 212-40-8532 Maryland Usual Residence of Decedent 10e Stete 10c City Town or Location 10b. County 10d. Inside City Limits tX Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 231 Canal Park Drive 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No tf Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 🎖 ☐ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 realtor realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George W. Wilkinson Eunice V. Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Benjamin W. Dennis (spouse) 231 Canal Park Dr., Salisbury, MD 21804

Oa. Method of Disposition

Observation of Disposition (Name of cametery, cremetory or other place)

October 1 Description of Date cametery, cremetory or other place) 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Mem. Gardens 12/28/98 Salisbury, MD 21. Signature of Funeral Service License 22. Name end Address of Fecility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, MD 21804
Do not enter the mode of dying, such as cardiac or respiratory arrest, Part | Enter the disease, or complications had caused the country short, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Deeth immediate Cause (Finai ne fastate Breast Gazen disease or condition resulting in death) 6 years Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco usa contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner certificete be exect P.O. Box 68760, Division of Vital

physiclan end s the burief-trans 98 for use es signed by been si certificate this funeral After death. or Attend efter death Director: / in by Hospital of 24 hours el To the Hosp within 24 hou To the Fune

**Physician** 

/Medical

Examiner

**Funeral** 

Director

must be notified at

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Hygiene.

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**Physician** /Medical Director

Funeral

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Completed

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Examiner

**Physician/Medical** 

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Certification:

Medical

29a. Certifler

(Check only

29b. Signature and title of certifier

the Manylend

death

Maryland 21215-0020

altimore,

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Registrar

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Mertin N.D. Vanes E. 31. Date filed (Month, Day, Year)
DEC 2 8 1998

32. Registrar's Signature reper

M19.

145 E. G. - 611 St. Salisbury

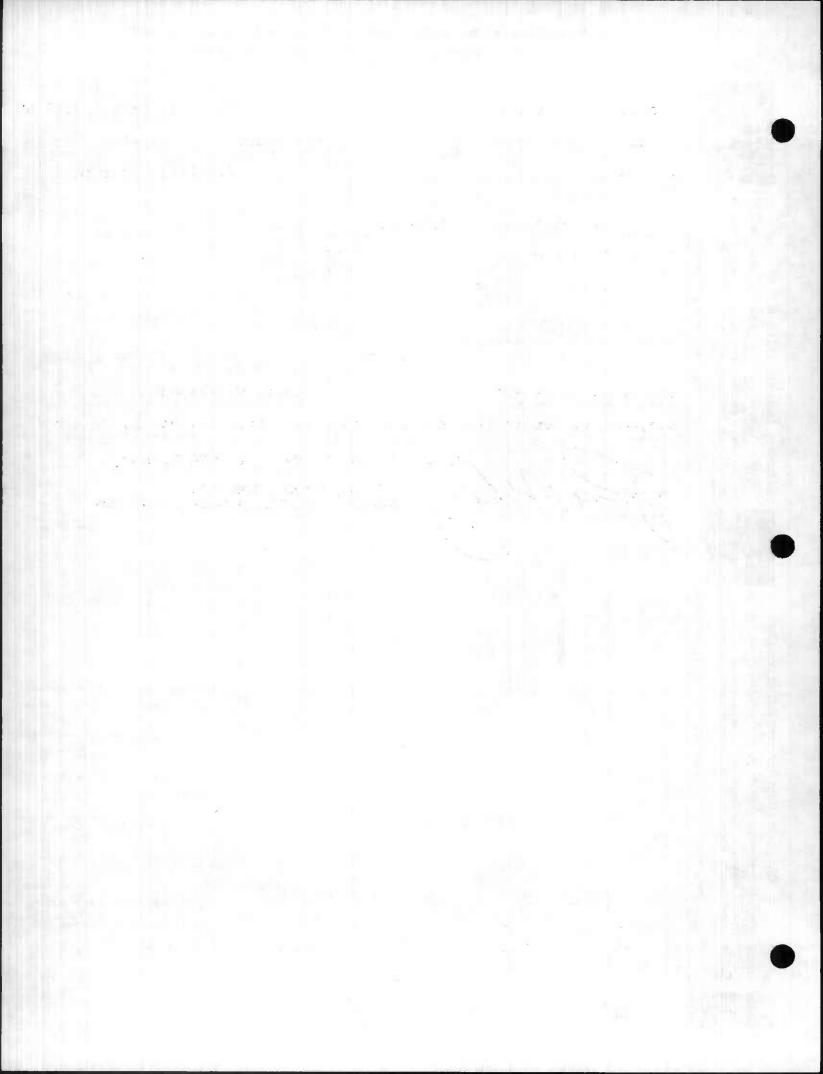
Territying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

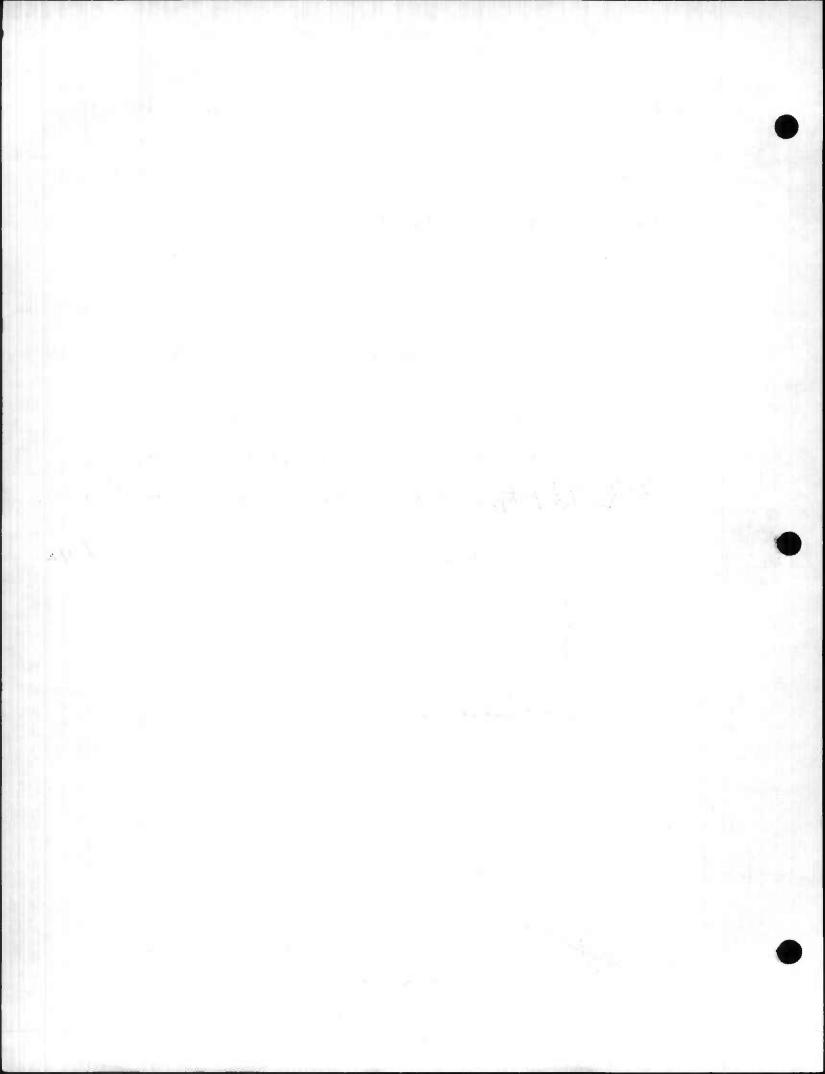
29c. License number

030690

29d. Date signed (Month, Day, Year)

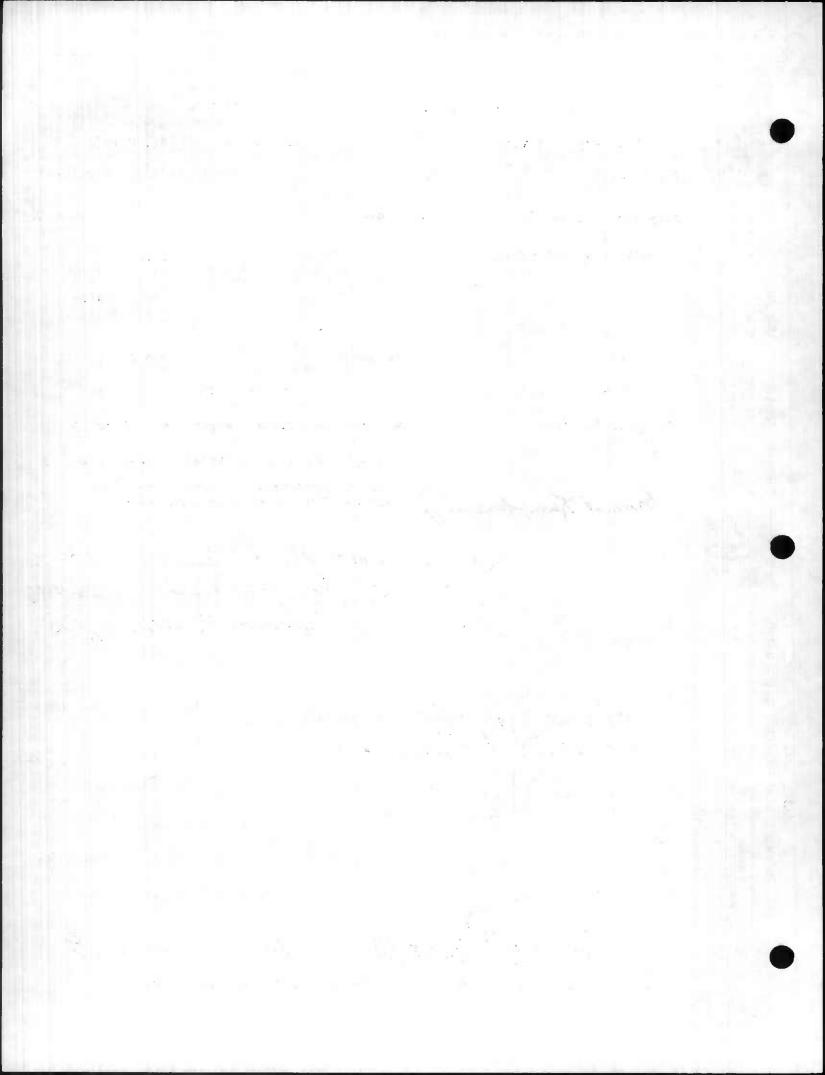


	_	Decedant's Nama (First, Middla, Last	State of Maryla		ertificate of			g. No.	41089
Physic		HORACE L.	DAUGHERT	V			Month		3. Tima of Death 8 6:20 AM
/Med Exami		4a. Facility Nama (If not institution, giva		1	4	lb. City, Town, or Lo		4c. County of	
LAMIN	1101	28149 NANTICOKE RD				SALISBUE		WICOMIC	
Funeral Director		241-32-7940	7. Aga (in yi	rs. last birthda 81 Yrs.	(y) ff Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, DEC. 23, 1	9916 NO	Birthplaca (State or Foreign Country) RTH CAROLINA
and *	7	Usual Rasidance of Decadant  10a. Stata 10b. County	100.0	City, Town or	ocation				10d. Insida City Limits
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r 28a	Director	MARYLAND WICOMI  10e. Straat and Number	CO	SALI	SBURY 10f. Zip Coda		10	og. Citizan of Wha	it Country?
th with		28149 NANTICOKE RD			21801			U.S.A.	
21215-0020  within 72 hours after death with the Maryland isne. Then "natural", or froms 23a or 28a-f show the Medical Exercise must be notified at	by Funeral	11. Marital Status  1 □ Navar Married 2 ☒ Married  3 □ Widowed 4 □ Divorcad	12. Was Decedant Evar in Armed Forcas? 1 XYas 2 No WW If Yas, Giva Yaar or Datas: ARM	TT	i. Was Decedant of Hill Yas, specify Cuba	ispanic Origin? (Spe in, Maxican, Puarto Specify:	ecify Yas or No- Ricen, atc.)	14. Race -	Amaricen Indian, Whita, atc. WHITE
	Completed	15. Dacedant's Edu (Specity only highest grad Elemantary/Secondary (0-12)	cetion a complated) Collaga (1-4or 5+)	(Giv lifa.	edent's Usual Occupi ra kind of work dona o DO NOT usa ratirad LESMAN	ation during most of worki d)	ng	16b. Kind of Busin	
and 212 be filed within that Hygiene. d other than event, me M		17. Fathar's Nama (First, Middla, Last)		JA.	LESTAN	18. Mothar's Nama			ISIKIBUIUK
Estrolar Should be and Mental is marked o	To Be	HORACE DA	UGHERTY			LYDIA	1	HEATH	
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0 0 0 1		20a. Mathod of Disposition 1 □ Burlal 2 □ Cremation 3 □ F 4 □ Donation 5 ☒Other (Specify)	lamoval from Stata	camatary, cr	position (Nama of amatory or other place			20c. Location - Cit HEBRON . M	
Dealtim permit. Pag Department Important: 1 any Injury o		21. Signature of Funeral Sarvice Licens	8a 0 0 1		22. Nama and Address OUNDS FUNE	ss of Facility		705 E.	MAIN ST.
		23a. Part1. Entar tha disaasa, or compl shock, or haart failura. List only or	ications that causad tha da	ath. Do not a	ntar tha moda of dyin	g, such as cerdiac of	r raspiratory arra		RY, MD 21804 Approximate
Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)		STOMAC	Н				Intarval Batween Onsat and Death
	ē	,	Dua to	(or as a cons	equance of):				
cate be executed physician and stree buriel-transit	Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying	Dua to	(or as a cons	equance of):				
E D6	Medicai	Causa (Disaasa or Injury that Initiated events resulting in death) Last		(or as a conse	aquance of):				
eath certification attending	cian	-							
the dy the coherence of	Physician/M	Part II. Other eignificant conditions cor	1.	asulting in tha	undarlying ceusa give	an in Part I.			bute to the cause of death?
L pag	by	- W	Kuro	n					Probably 4 🖔 Unknown 4b. Wara autopsy findings
2 8 8	Completed		11176				24a. Was ar perform	led?	available prior to completion of cause of death?
VICIAN: The la certificate ha							1 □ Ya		1 ☐ Yas 2 ☐ No
OI VILA Physician: this certific ral director,	o Be	25. Was cesa rafarred to medicel axaminar?  1 ☐ Yas 2 ☒ No	lospital:		ont 20 DOA Othe	28. Placa of Death ar:			
E g je	tion: To	27. Mannar of Death  1 Natural 5 Panding 2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Tima	of 28c. tnjun	4 LI Nursing Hor		nce 6 Other ( w injury occurred	Specify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Affei completely filled in by the fune	Certification:	3 Suicida 6 Could not be detarmined	28a. Place of Injury - At building, atc. (Spe	home, farm, s		1100	28f. Location (Str City or Town		or Rural Routa Number,
Hospita     124 hours     Funeral letely filler	edical C	29a. Cartifler (Check only one)  12 Certifying Physical Examination (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledga, das nation and/or i	ath occurred at the time investigation, in my op	ne, data and placa, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manna ite and place, and	ar as stated. I dua to the ceuse(s)
To th To th comp	Me	29b. Signatura and titla of certifar			29c. Licanse	a number	29	d. Data signed (A	Nonth, Day, Year)
, a						D47637		12-23-	98
5+11		30. Name a of er on who co JOSEPH INZERILLO,				SURY, MD 2	1804		
St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 2 3	32. Registrar's Sig	nature	& Spo	re Kal			



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

	1. Decedant'a Nama (First, Middla, Last)						2. Data of Death Month	Dev	Year	3. Tima of Death
sician edical	Haze1	Unive	Dean				Decembe	r Day	1998	2:10 AM
miner	4a Facility Nama (If not institution, giva st	reet and number)				lb. City, Town, or I	ocation of Death	4c. County	of Death	
	St. Mary's Hos	spital				Leonard			Mary'	S
ıl r	5. Social Security Number  218-30-4126  Uaual Rasidance of Dacedant	7. Aga M 201 F	(In yrs. last birti	Montha Montha	1 Yaar Daya	If Under 24 Hra. Hours Min.	8. Data of Birth (Month, Day, May 23,	Year) 1926	9. Birthple Count Vi	ace (Stata or Foreig ry) rginia
	10a. Stata 10b. County		10c. City, Town	or Location					10	d. Insida City Limita
Funeral Director	Maryland St. Mary	s	Ca	llaway						1 ☐ Yaa 2 🕱 No
	10e. Street and Number			10f. Zip	Coda		10	g. Citizen of	What Count	ry?
	19989 Piney Point	Road			206	20		U.S.A		
	11. Marital Status	2. Was Decedant E Armed Forcas?	var in U,S.	13. Waa Deced	lant of I-	lispanic Origin? (S an, Maxican, Puart	pecify Yas or No-		e - Amarica	
	1 Nevar Married 2 Married 3 X Widowad 4 Divorced	1 ☐ Yas 2 🛣 No If Yas, Giva Yaar or Datas:	0	1 ☐ Yas		Specify:	o riioan, uto.,	Specif		ite
	15. Decedant's Educa (Specify only highast grada	ntion completed)	16a.	Decedant's Usua	al Occup	ation during most of wor	kina	6b. Kind of B	usiness/Ind	ustry
	Elamentery/Secondery (0-12)	Collega (1-4or 54	+)	lifa. DO NOT us	a retire	during most of wor				
l	8th		I	lomemake	r		400	_Own_		
	17. Fathar's Nama (First, Middla, Last)						na (First, Middla, M	laidan Suman	na)	
	Dallas Selle		Lan		10.	Bertie		-	0	0.4.
1	19a. Informant's Name/Ralationship (Type	e, Print)					ıral Routa Number,			
	Jerry W. Dean/Son 20a. Mathod of Disposition	10	20b. Piaca of	1930 Pea Disposition (Namer, cramatory or o	na of	III Lane,	Leonard Data 2	Oc. Location		
ĺ	1 XBurial 2 ☐ Cramation 3 ☐ Ra	moval from Stata								
	4 □ Donation 5 □ Othar (Specify)  21. Signatus of Funaral Sarvice Licansee		Charles				12/22/98			own, MD
	21. Signatus of Furtaral Sarvice Licansee	1	10	Mattin	gle	-Gardine	r Funera	1 Home	, P.A	
4	23a. Part 1. Enter the disease, of complice shock, or heart failure. List only one	Sardin	er X				rdtown, l			Approximate Intarval Between
Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last  d.	Jen Jen	Due to (or es a co	mad	TA	Mari	otela	s rota		3 days
,	Part II. Other significant conditions contr	ibuting to death but	t not rasulting in	the undariying c	ausa gh	an in Part I	1			the cause of death
	Chronic	Helm	chie	ulnur	nou	ME	- 1000	2 □ No	3 Prob	ebly 4 Unknov
	Carolie	K An	long	De	7		24e. Wes er perform	n eutopsy ned?	cor of c	are autopsy findings allable prior to impletion of cause death?
מ	25. Was casa rafarred to medical		- V			26. Place of Dec	ath (Check only one	9)		
0	axaminar? 1 ☐ Yas 2 Z—o	spital: 1 Inpatier	t 2 ER/Out	patient 3 DC	OA Oth	and the same of th	loma 5 ☐ Raside	-	nar (Specify	1)
edical certification.	27. Mannar of Death 1 Natural 5 □ Panding	28a. Data of Injung		ma of 2	Bc. Injui	y at k?	28d. Dascribe ho	w injury occu-	rred	
	2 Accidant invastigation	1,100,100		М		Yas 2 □ No				
	3 Suicida 6 Could not be determined	28a. Pleca of Inju- building, atc.	ry - At homa, far (Specify)	m, straat, factory	, office		28f. Location (Sti City or Town	reet and Num. Stata)	ber or Rura	I Routa Number,
	29a. Certifier (Check only one) 1 Sertifying Physic 2 Medical Examine	clan: To the best of er: On the basis of and manner stat	axamination and	death occurred /or invastigation	at the tie , In my c	ne, dete end plece pinion, daath occu	, and dua to the ca irred at tha tima, da	usa(s) and m ita and place,	anner as st and dua to	ated. tha cause(s)
- 1	29b. Signatura and tilla of certifiar	11)	11	290	. Licans	a number	25	d. Deta signe	d (Month, i	Day, Year)
		MIN	16.10	- 111	97	0/(1	14	111	7/-	יאין
Σ	30 Nama and a defrace of paragon who	ed V	Ath (Item 33a)	Type Print	1	COT		5-0	4-/	0
2	30. Nama and address of person who com JAMES P. JARBOE M.J	pleted cause of de			ICA	COT CENTER	HOLLYWOO	D, MD. 2	0636	0



State of Maryland / Department of Health and Mental Hygiene \( \)

Certificate of Death

п	Di	. 1	1. Decedant's Name	e (First, Middla, La	ist)						2. Data of D	aeth		Vere	3. Time of the
	Physic /Medi		MELVIN	EDWARD	DAWSON	1					DECEME	ER :	24,19	98	11:25 A.M.
	Exami		4a. Fecility Nama (/	f not Institution, giv	a street and numb	per)				4b. City, Town, o	Location of Dea	th 4	c. County	of Death	
			MEMORI	AL HOSP	ITAL					CUMBER	LAND		ALL	EGA	NY
	Funeral Director		5. Sociel Sacurity N  214-07- Usual Residence of	2838	Sax 7.	Aga (In yrs. la	rst birthdey) Yrs.	If Under 1 \ Months D	reer leys	If Under 24 Hr Hours Mir		inth ay, Yaa , 191	r) 5 A		placa (Steta or Foreign ntry) LAND
	show		10a. Stata	10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	filed within 72 hours after death with the Maryland thygiene. ther then "natural", or frems 23a or 28e-f show out, the Medical Examiner must be notified at	tor	WV	MINER	AL	RI	DGELE	Ϋ́							1∑ Yes 2□No
	or 28	Director	10e. Streat end Nur	mber				10f. Zip Co		1		10g. C	Itizan of W	/het Cou	ntry?
	th w		40 POT	OMAC ST	REET			-215					U.S.	Δ.	
	dea	Funeral	11. Marital Status	OTATO DI	12. Was Daceda Armed Force	ant Ever in U,S	3. 13. V			ispanic Origin? ( an, Maxican, Pue	Spacify Yes or N	0-	14. Rece	- Amari	can Indien,
0	or h		1 Never Marri	ad 2 Married	1 Yas 2	No				Specify:	nto rican, atc.)			k, White	
00	ours Fair,	1 by	3 X Widowed	4 Divorced	Yaar or Data	as:		☐ Yes 21⁄2	INO	<i>Зреспу:</i>			Specify:	WH	LTE
21215-0020	d within 72 hours liene. r then "netural", the Med cal Exc	Completed	(Spec	15. Decedant's E	ducation ada complated)		(Giva)	ant's Usual O	lona	during most of w	orkina		Kind ot Bu		
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	Hygie ther ther the		12	/F1			CHIE	F DIS	SPA	ATCHER			ILWA		
Maryland	S T S	Be	17. Fathar's Nama (	DWARD D							ma (First, Middle MAY D			a)	
N	should be nd Mentel marked or	10													
Mai	0 0 0		19a. Informant's Na		Type, Print)					and Number or F					o Coda)
	of Heelth Itam 27 I		LEROY  20a. Method of Disp			and Di		BOX sition (Nama		21 – RI		-		753	
Baltimore,	of of		1 X Burial 2		Removal from Sta	ate ce	malary, cram	atory or other	r pla	,	Dala 12/28/98				own, State
Ball	permit. Pag Department Important: I any Injury o		21. Signatura of Fu	nerel Service Lice	nsee		U 22	Nama and A PCHUR	ddre CH	ss of Facility FUNER NE ST.	AL HOMI	E, E	P.A.	MD	21502
	Physician		23a. Part1. Enter the shock, or haar	e diseasa, or com t failura. List only	plicetions that caus one cause on each	sed the daath. h lina.	Do not ante	r tha mode of	t dylr	ng, such as cardia	c or raspiratory	errast,	,		Approximeta Intarval Batween Onsal and Death
	/Medical		Immediata Ceusa (	Final	INTRA	CTABLE	CONGE	STIVE	HE	ART FAII	URE			-	1 YEAR
н	Examiner		rasulting in death)		a	Dua to (or	as a consequ	uanca ot):						-	
Н	D tis	ine			PROST	ATIC CA	ARCINO	MA						1	1 YEAR
	icate be executed physician and s the buriel-transit	Examiner	Sequentially list cor if eny, leading to im causa. Enter Under Ceusa (Disaasa or	nditions, madiata	D	Dua to (or	as a consequ	uance ot):							
9	be e ician burie		Causa, Entar Unda Ceusa (Disaasa or that initiated avants	rlying injury	c										
x 68760,	certificate be executed ding physician and use as the buriel-transit	Physician/Medical	resulting in death) L	est	4	Due to (or	es e consequ	ence of):						į	
Box	tte	Ician	Part II. Other signifi	cant conditions of	ontributing to deat	h but not recul	ting in the un	darheina anua	o oh	ron in Port I	22h Die	toheno	A 1100 000	tulbuda t	o the cause of death?
P.0	uires that the dea signed by the e id be detached for		Tarrii Star algimi		Only Double to Godin	III Dat IIot Iasur	ung m tha tin	danying caus	e giv	en in reiti.			1/		bably 4 Unknown
ecords,	tw requires that the s been signed by the 2 should be detache	pleted by									24e. We	s an aut ormed?	opsy	9/	dara autopsy tindings vailabla prior to omplation of cause death?

Division of Vital Be

07

DAWSON, MELVIN

director, page 2 s or Attending Physician: To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral (

2

29a. Cartifier 29b. Sign

27. Menner of Deeth

1 Netural

2 Accident

3 Suicida

4 Homicida

25. Was case rafarrad to madical examinar?

2 No

Cartifying Physician: To the best of my knowledge, deeth occurred at the lime, deta and place, and due to the causa(a) and menner as stated.

Madical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) and manner stated. ure and title of cartifia

5 Panding invastigation

6 Could not ba

28a. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify)

Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28a. Data of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Yas

Dete signed (Month, Day, Year)

1 ☐ Yas 2 ☐ No

1 Yas

28d. Dascribe how injury occurred

28. Placa of Daath (Check only pris)

Other: 4 Nursing Homa 5 PResidence

2 2 No

6 Othar (Specify)

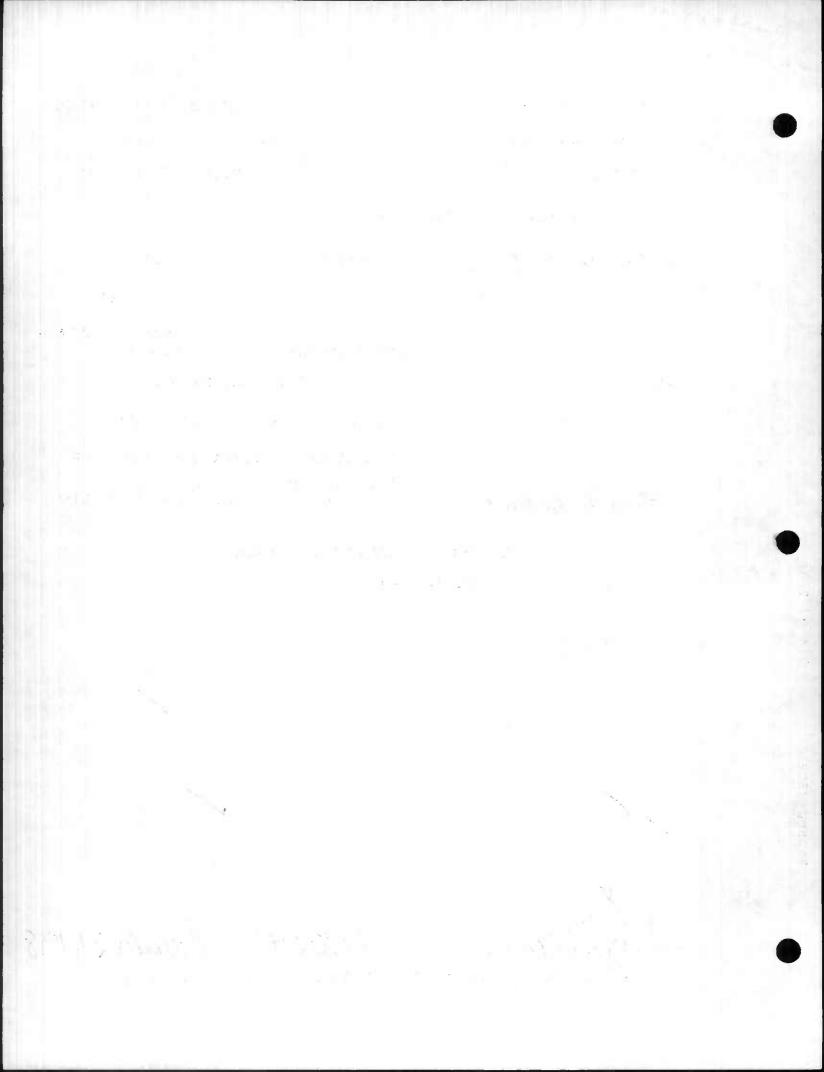
28f. Location (Straat and Number or Rurel Route Number, City or Town, State)

30. Name and address of parson who completed causa of death (Itam 23e) (Type, Print)

Terry Williams, M.D., Memorial Medical Building, Cumberland, M.D. 21502

State Registrar 31. Data flied (Month, Day, Year)
DEC 3 0 1998

32. Registrar's Signatura



**Physic** /Medi Exami

**Funeral** Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, the Medical Examine must be notified at page.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0020

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State	of Maryla	and / [				Health : Death		Mental H	ygier Reg. I	20	4	092	
1. Decedent's Neme (Fit	rst, Middle, La	ist)		-						2. Dete of D				3. Tima of	Deeth
JAMES CUR			V.,							Decemb	er	28,	1998	8:35	p.m
4a Facility Neme (If not	institution, giv	e street end n	ımber)					4b. City, To	own, or L	ocation of Dec	eth /	4c. County	of Death		
Memorial Hos	spital	& Medi	cal Ce	nter				Cumbe	rla	nd		Alleg	gany		
5. Social Security Numb	er 6. 5	Sex	7. Age (/n )	rs. last bir	thday)		r 1 Yee			8. Dete of B	irth	e el	9. Birthp	lace (State o	r Foreign
214 16 230 Usuel Residence of Dec	0	1 XM 2□ F	86		Yrs.	Months	Deys	Hours	Min.	9-2	L-12		PA	nry)	
	. County		10c.	City, Tow	n or Loc	ation							1	0d. Inside Cit	v Limits
	omerse	t		eller										1X Yas	*
10e. Street and Number						10f. Zi	p Code				10g. (	Citizen of	Whet Cour	ntry?	
12128 Rout	e 160-	-P. O.	Box 56	5		155	564				US	SA			
11. Maritel Stetus	- 100		cedent Ever is		13. W			Hispenic Or	rigin? (St	pecify Yas or N	lo-	14. Red	e - Americ	an indien,	
1 Never Merried 3 Widowed 4	**	Armed F	orces? 2X No ive	., 0,0.	If	Yes, spe	ecify Cul	ben, Mexica	n, Puerto	Rican, etc.)		Ble	ck, White, y: Whi	etc.	
15.	Decedent's E	ducation		16a.	. Decede	ent's Usu	Jei Occu	pation			16b.	Kind of B	usiness/inc	dustry	
(Specify or	nly highest gr	ade completed			(Give k	and of wo	ork done	during mos	st of worl	king					
Elementary/Secondar	y (0-12)	College	(1-4or 5+)								Ma	mufa	cturi	na	
17. Fether's Neme (First	Adiddle Lee			Me	char	nic_		10 Moth	or's Nom	ne (First, Midd				.IIg	
George Wil										bel Su		on Suman	110)		
19e. informent's Neme/ Zelda R. D		,, ,		19b	. Meiling	g Addres	s (Stree	Well	er or Ru	ral Route Num		y or Town	State, Zip	Code)	
		ouse	100	b. Plece o						Date			O11 T .	01161	
20a. Method of Dispositi XXBuriel 2 Cr 4 Donetion 5	emetion 3		Stete	cemete	ry, crem .awn	Memo	other pl	al Gar		12-31			ale,		
21. Signature of Funera	/	7.4	all	1	Ha	arve	v H.	Zeig	1er	Funera	1 Hc	ome			
23e. Pert1 Enter the di shock, or heart fail	s e e or con e. List only	plicetions the one cause on	daused the d each line.	leeth. Do	not ent	r the mo	de of dy	ring, auch as	scardiec	or respiretory	arrest,		1	Approximate Interval Beh Onset end I	ween
Immediete Cause (Fine diseese or condition	í	CED	EBROVA	SCIII	AD A	CCTT	TMT						1	24 MON	THS
resulting in deeth)		e. CER												24 11011	1110
		h	Due	o (or as e	consequ	uerice or;	).						1		
Sequentielly list condition if eny, leeding to immediately cause. Enter Underlying Cause (Disease or injuriately in the condition of the condi	ons, liate		Due t	o (or es a	consequ	uence of)	):						1		
thet initiated events resulting in death) Lesi	1	С.	Due le	o (or es e	consequ	ience of)	:								
		d													
Pert II. Other eignificant	t conditione	contributing to	deeth but not	resulting i	n the un	derlying	cause g	iven in Pert	l.	23b. Di	d tobac	co use co	ontribute to	o the cause o	of death
										1 (	Yes	2 No	3 Pro	bebly 4 🗆	Unknow
			14							24e. We	s en eu riormed	itopsy ?	av cc	ere autopsy frailable prior to empletion of condeath?	0
										10	Yes	2 <b>3</b> No	10	□Yes 2Kd	No
25. Was case referred to	o medical						-	26. Plac	e of Dea	th (Check onl	v one)		1		
examiner? 1 ☐ Yes 2 ☑ No		Hospital:	Inpatient :	2 □ ER/Oi	utpatient	3□ D	OA O	ther.		ome 5 Re		6 □O#	her (Specia	fv)	
27. Menner of Deeth 1. Neturel 5	☐ Pending	28e. Date (Mo		28b.	Time of Injury		28c. Inj W			28d. Describ				71	
2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined	28e. Plec	e of Injury - A	At home, fe	erm, stre				2110	28f. Location City or 7	(Street	t and Num	ber or Run	al Route Num	ber,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burial-trensit Division of Vital Records, P.O. Box 68760, James Dom 214-16-2300

Medicai Certif m

29e. Certifier (Check only one)

29b. Signeture and title of ceg

State

31. Dete filed (Month, Day, Year)
DEC 3 0 1998



30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

Robustiano Barrera, M.D., Memorial Hospital Medical Building, Cumberland, MD 21502

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

D14865

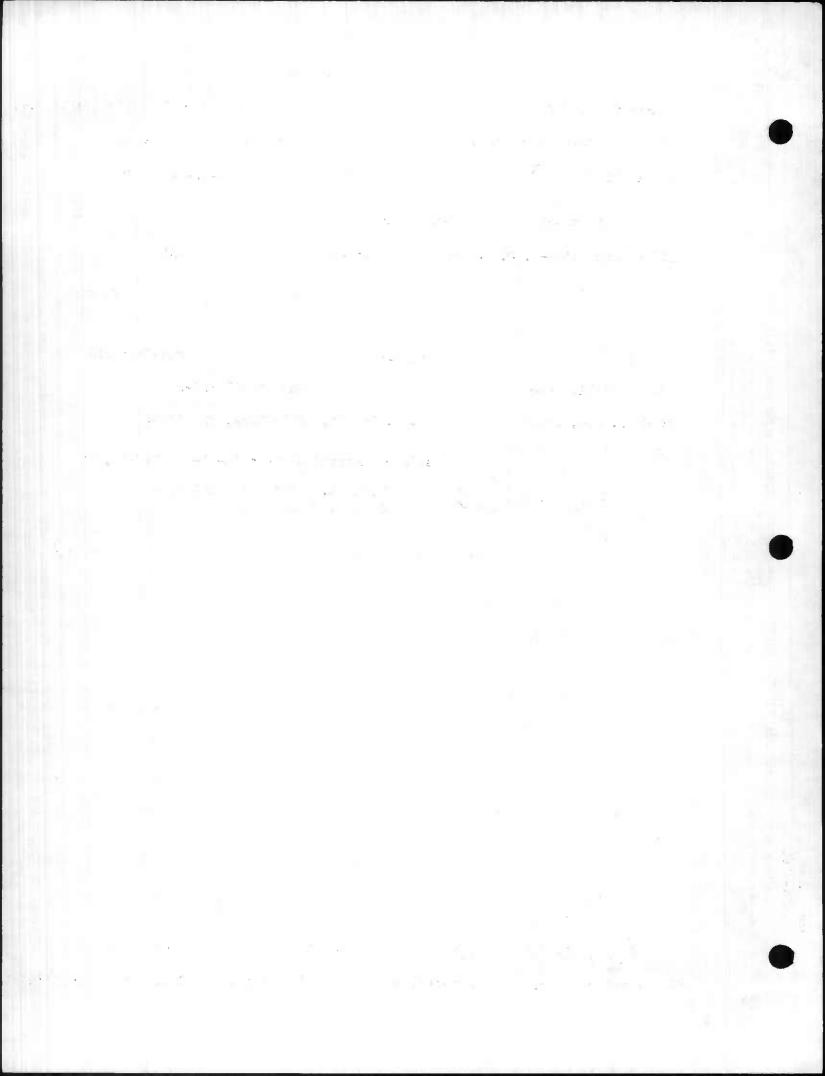
29c. License number

29d. Dete signed (Month, Day, Year)

December 1998

**DHMH 16 Rev 6/95** 

Registrar



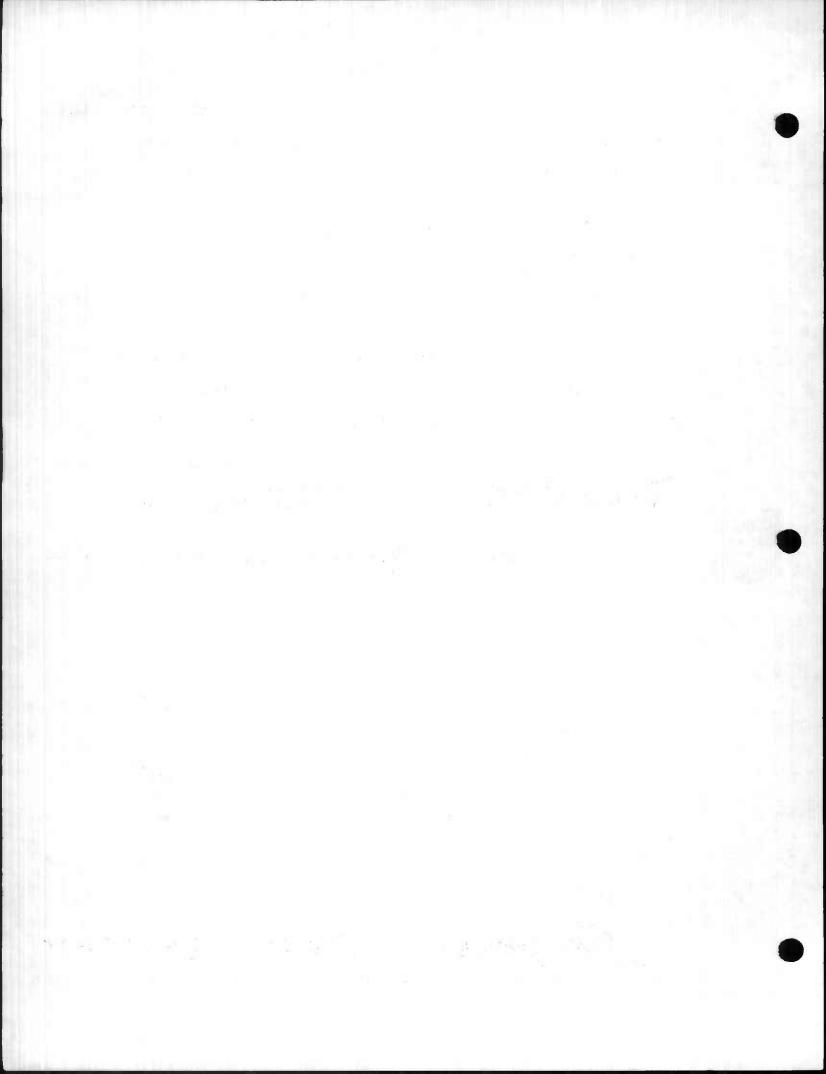
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year JAMES MORTIMER DICKINSON DECEMBER 22 1998 10:48AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Yeer) **Funerai**  Birthplece (State or Foreign Country) Deys Hours 1 MM 2□ F Yrs. Director 220-30-8262 62 OCT 1 1936 MARYLAND Usuel Rasidence of Decedent the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 Yes 2 No Directo W. VA. MINERAL FORT ASHBY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 116 ERIC LANE 26719 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritei Stetus e filed within 72 hours after al Hygiene. other than "natural", or ite Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 +PHARMACIST PHARMACIST 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Surneme) 2 should be fi and Mentel H Be тагкед 2 ALBERT J. DICKINSON OPAL L. THOMAS 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 st Department of Health and Important: If item 27 is n any injury or other treun W.VA. 26719 JOANN DICKINSON WIFE 116 ERIC LANE FORT ASHBY 20b. Plece of Disposition (Name of cematery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUNSET CEMETERY DEC 24 1998 CUMBERLAND MARYLAND 21. Signeture of Funerel Service Licenses 22. Neme end Addrass of Fecility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Port1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one ceuse on each lina. Approximate tntervel Between Onsel end Deeth **Physician** MUDITARDIA INFARCTION /Medicai Immedieta Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner buriel-transit Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of) physician a Box 68760 99 Physician/Medical Due to (or as a consequence of): 98 attending USB Pert II. Other significant condittons contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco usa contribute to the causa of death? the been signed by should be detac 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ The law requires 24b. Ware autopsy findings evellable prior to completion of cause of daath? 24e. Was en eutopsy performed? Completed page 2 certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Certification: To 3□ DOA 1 Inpatient 2 PR/Outpatient 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, fectory, offica building, atc. (Specify) 4 Homicide 12 Ortifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as stated.

Medicat Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner steted. 29a. Certifier Medical 29b. Signatura end title of 29c. License number 29d. Dete signed (Month, Dey, Year) m 10 30. Neme and eddless of person who pleted cause of daeth (Itam 23a) (Type, Print) DR GARY L. WAGONER 925 BISHOF WALSH DRIVE CUMBERLAND MARYLAND 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 24** Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month DURR 41) MAINSON MATHIAS 1998 December 4a Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death CUMBERLAND H Under 1 Yaar H Under 24 Hrs. 8. Data of Birth Months Deya Hours Min. (Month, Day, Year) MARCH 28, 1914 SHORED HEART HUSGITAL A11059hy 5. Social Security Number 6. Sex Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) MARYLAND 120 M 2□ F Yrs. 84 217-10-6225 Usuai Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND ALLEGANY RAWLINGS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21557 USA P.O. BOX 183 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritai Status 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian. Biack, Whita, atc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Nevar Married 2 Married 1 Yaa 2 No Specify: Specify: WHITE 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE LANDLORD 8 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) REBECCA MILLER LOUIS DURR 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) HILL TOP DRIVE, CUMBERLAND, MD MANSON DURR, JR./SON DEC 27,1998 20c. Location - City or Town, State 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata OAK GROVE MENNONITE CEMETERY GRANTSVILLE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 25 Signature of Funeral Service Licensee 22. Name and Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY (a) 1302 NATIONAL HWY, LA VALE, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final hours ASDIRATION diaeasa or condition rasulting in death) cute 1101 05 Dua to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NEIMONI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TO Yes 212 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. Stata

**Funeral** 

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

Director

Funeral

p

Completed

Be

the Maryland

death

filed within 72 hours after Hygiene. Wher than "natural", or its

permit. Pages 1 and 2 should be filed will Department of Health and Xental Hyglen, important: if item 27 is marked other tha any injury or other traumatic event, the kends.

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records.

Division of Vital

Examiner Physician/Medical Completed by Be Certification: To

the death certificate be executed physician and s the burial-transit signed by the a this After or Attending after death. To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by

15 State Registrar

Medical

DU NALL) 31. Data filed (Month, Day, Year)

Sequentially list conditions, if eny, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Part II. Other algnificant conditions contributing to death but not rasulting in the undarlying causa given in Part I. Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Naturai 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and mannar stated. 29a. Cartifier (Check only one) 29b. Signatura end title of certifian 29c. License number 29d. Data signed (Month, Day, Year)

DHMH 16 Rev 6/95

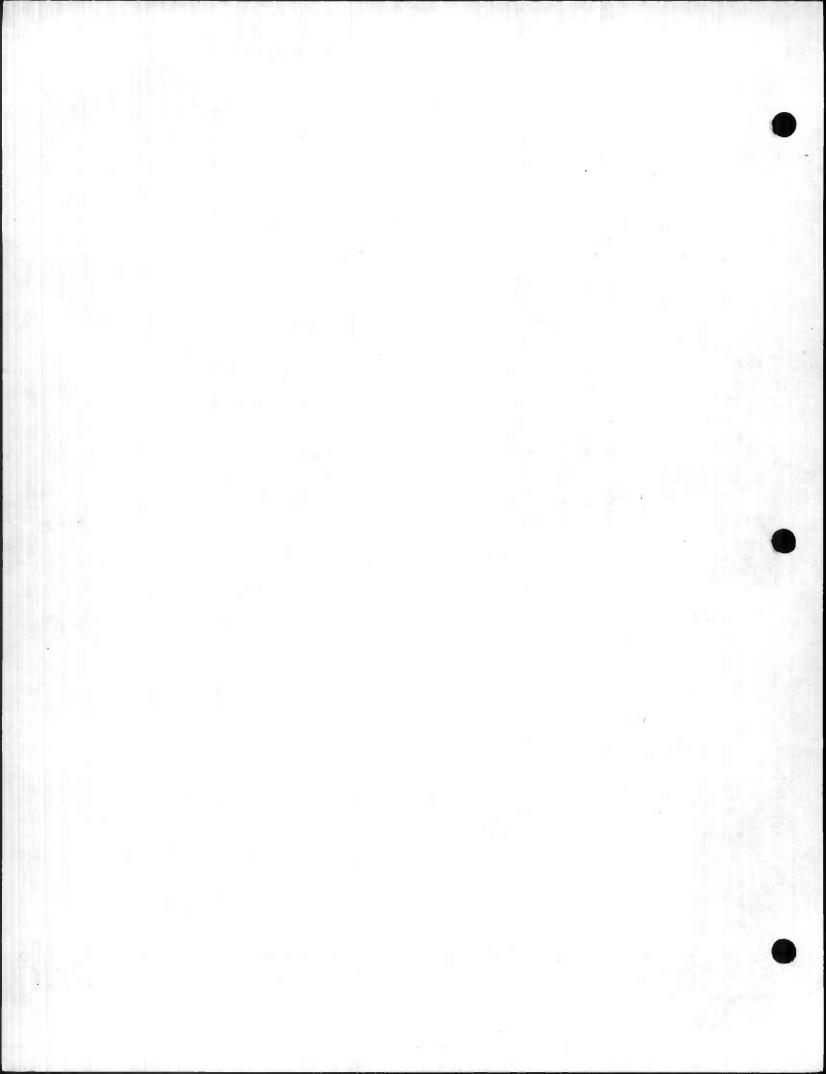
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Bedforn Ruan Cumbet

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

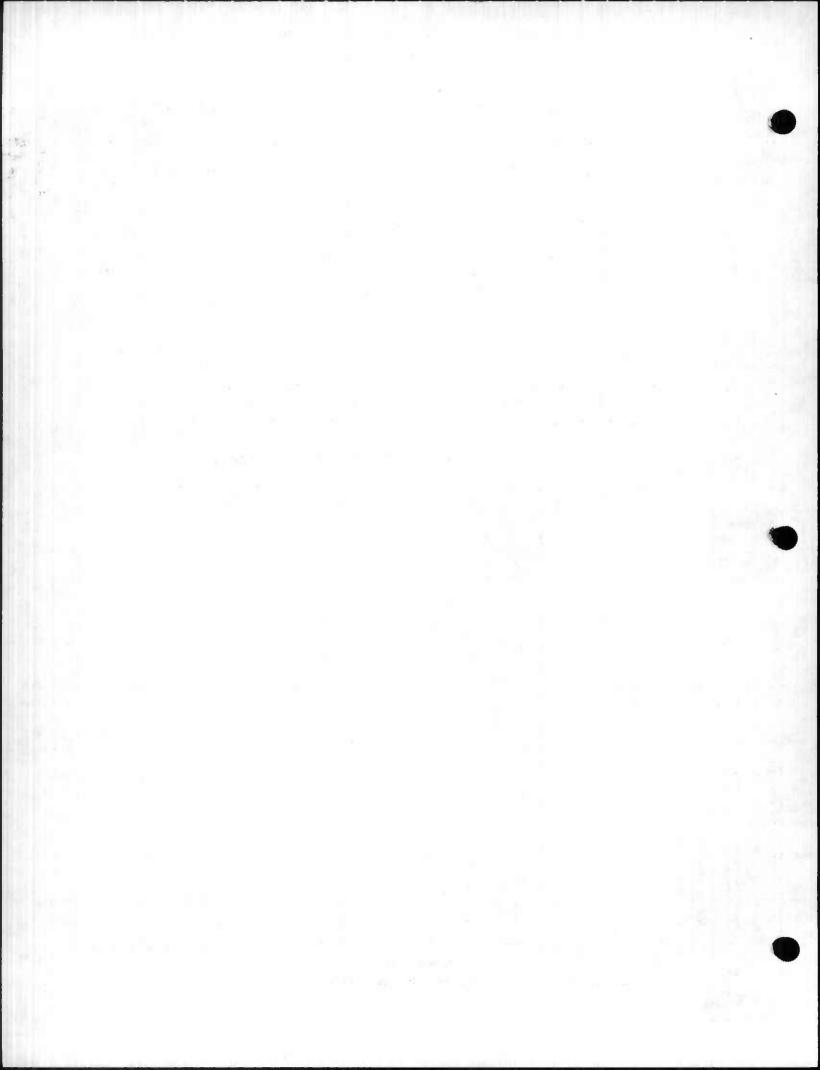
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32. Registrar'a Signatura



State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Security		5. Sex 7.	Aga (In yrs. le:		er 1 Year	If Under 24 Hrs.	6. Data of Bir	th		ace (State or Fo
Director		220-28 Usual Rasidanca		1□ M 21XF	65	Yrs. Months	Days	Hours Min.	6. Data of Bir (Month, Da May	y, Year) 5, 1933	Count	ace (State or Fo
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	REGISTRAR		ARTMENT OF H		MENTAL HYGIEN REG. NO	_	*
	1. DECEDENT'S NAME (First, Middle, Last) DR	IVER	2		2. DATE OF DEATH MONTH DEC	~21-19	3. TIME OF DEATH  9 AM M
	578-70-6143 XX м ₂ □ ғ	1. AGE (In yrs. lest birthde 44 YRS	MONTHS DAVE	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year) 4-25-54	C	IRTHPLACE (State or Foreign Sountry) Ashington, DC
OB	9e. FACILITY NAME (If not institution, give street and number) HEARTLAND HEALTHCARE OF HY.	ATTSVILLE		tsville	ATH	9c. COUNTY C	
DIRECTOR	10a. STATE 10b. COUNTY D.C. N/A		arry, town on Locat			•	10d. INSIDE CITY LIMITS?
FUNERAL (	10o. STREET AND NUMBER 911- Quincy Street, N.W			20011		tog. CITIZEN	XX YES 2 ☐ NO  DF WHAT COUNTRY?
NO.	11. MARITAL STATUS 12. WAS DECEDENT	EVER IN U.S. ARMED YES 2 X NO	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No- 14, F	IACE — American Indian.
B	3 Widowed 4 Divorced IF YES, GIVE WAT	OR DATES		-	n, Puerto Rican, etc.)		pecky White, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)	IMB. DO NOT	'S USUAL OCCUPATION work done during mo use retired.)	1	16b. KIND OF BUS	SINESS/INDUSTR	Y
OMP	12th 17. FATHER'S NAME (First, Middle, Last)	Const	ruction W		N/A ME (First, Middle, Maiden	Summer!	1
BE C	Bernard Saunders			Barba	ra J. Driv	er	
10	Barbara J. Driver/Mother		Quincy S		oute Number, City or Town		D.C. 20011
	20a. METHOD OF DISPOSITION 1 □ Burlel 2 X Cremation 3 □ Removal from State	20b. PLACE AND DAT	E OF DISPOSITION (Na	me of		CATION — City o	r Town, State
	4 □ Donation 8 □ Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Riverdal	22. NAME AN	D ADDRESS OF FAC	CHLITY		
	Melta W. Hac	kat	814-	Upshur.	neral Chap Street, N.	W.	•
	23. PAPT I. Eriter the diseases, or complications that a shock, or heart failure. List only one bause IMMEDIATE CAUSE (Finel disease or condition resulting in death)	RD/O	not enter the mo	de of dying, such	ee cerdlec or reeplection of the cerdlect or reeplection of th	ALUK	Approximete Interval Between Onast and Death
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ICATI	cause. Enter UNDERLYING	7P4	STAPS	15			
CERTIFICATION	that initiated events resulting in death) LAST	H AS A CONSEQUENCE	of: 5	1ND/	28MR		8
	PART II. Other algnificent conditions contributing to de	eath but not resulting	g in the underlying	cause given in	Part I. 24e. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
PHYSICIAN: MEDICAL						Xno	COMPLETION OF CAUSE OF DEATH?
N.	DID TOBACCO USE CONTRIBUTE TO CAU			UNCERTAIN	10		
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1   Input   1   Input   2   F	26. PLACE OF DE	OTHER:		Ta Assaulta		
	27. MANNER OF DEATH  1 Netural 5 Pending  280. DATE OF IN (Month Dear		IME OF 28c, INJUNION WOOD	RK?	28d. DESCRIBE HOW IT	NJURY OCCURED	,
red BY		NJURY — At home, farm	, street fectory, office		281. LOCATION (Street a City or Town, State)	and Numberor Ru	ral Route Number,
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of m						
	22 MEDICAL EXAMINER: On the best Pof examiner 29b. SIGNATURE AND TITLE OF CERTUPER	nination end/or investiga	tion, in my opinion, de				
TO BE		MD	A	D 42	0,19	DATE SIGN	Le 215798
	30. NAME AND ADDRESS ON PENSON WHO COMPLETED CAUSE	UD TEMPONY	Car'	1350	AND	207	N Res

32. REGISTRAR'S SIGNATURE

Carrie 2 2001 1 5 330

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 0/4 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ALONZO 3:35 PM DOSWELL /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON PARK MUNICUMENTY ADVENT 4KOM tto soita 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 10 M 20 F Yrs. 577-70-7134 Director 07/07/53 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Directo Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23s or 5465 16th Avenue 20782 United States death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 natural', or Specify: Black 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) pernit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if item 27 is marked other th any Injury or other traumatic avent, the 12 Government Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Pride Kermit Doswell 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5323 Chillum Place, N.E. Washington, D.C. 20011 Margaret Doswell / Mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, cremetory or other place) 1 Buriet 2 Cremetion 3 Removel from Stete 12/22/98 BRENTWOOD MD. 4 ☐ Donetion 5 ☐ Other (Specify) I. I.N.C.O.L.N. C.F.M.
22. Name and Address of Facility FT 21. Signature of Funeral Service Licenses ALEXANDER S. POPE FUNERAL HOMES M859 2617 Pennsylvania Avenue, SE DC 20020 23a. Part1. Enter the disease, or compilations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical tmmediate Cause (Finel clays nage WITH CEREBRAK disease or condition resulting in death) Examiner Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): USB 85 P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 3 Probably 4 Unknown bengis Records, Ag 24b. Ware autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1)Sunpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? Affer 5 Pending investigation Attending Natural death. 1 Yes 2 No I hours after death. uneral Director: A sly filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homlcide Hospital or To the Hospital or within 24 hours aft to the Funeral Dis completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted. Medical 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 83

30. Name and address of person who completed cause of death (ttern 23a) (Type, Print)

32. Registrar's Signa

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	10	Theodore L. Mil	es				Arlin	e Wise				
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DHMH 16 Rev 6/95

State Registrar

31. Data filad (Month, Day, Year)
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Please Type or Print in Black Indelibie ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 20, 1998 **Physician** 09:18 PM Herman Soogrim DeFreitas /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1₩M 2□F 59 Director December 5, 1939 Guyana, S. America 578-98-9585 the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits re 23a or 28a-f show inval be notified at Director 1 X Yes 2 □ No Maryland | Prince George's Cheverly 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 1807 62nd Avenue 20785 Guyana, South America Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 7 is marked other than "natural", or items traumstic avent, the Medical Examiner my Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 24 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Mechanic 8th Private permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked oths any injury or other traumatic avent bloce. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Norman Persaud Stella Defreitas 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Doreen DeFreitas/Wife 1807 62nd Avenue, Cheverly, Maryland 20785 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 12/24 1 X Buriei 2 ☐ Cremation 3 ☐ Removal from Stete Landover, Maryland Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 1998 21 Signature of Funeral Service Licensee 22. Name and Address of Facility J.B.Jenkins Funeral Home 23a. Pent1. Enter the disestant or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximete intarvai Between Onset and Deeth **Physician** /Medical Immediate Cause (Finei ARTERIOSCUEROTIC CARDIOVASCULAR disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner burial-transit and Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician Box 68760 certificate be Physician/Medical the Due to (or as a consequence of) 100 use o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached P.O. signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No MELLITUS Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? has page 2 2 No 1 Yes 2 No t□Yes certificata director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient this funeral 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After A Hospital or Atten-24 hours after death. A Director: AF 1 Naturei 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 8 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier 29c. License number

ed cause of deat (Item 23a) (Type, Print)

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3. Registrer's Signeture

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DHMH 16 Rev 6/95

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Registrar

30. Nema end eddress of person who complete

DEC 2 3 1998

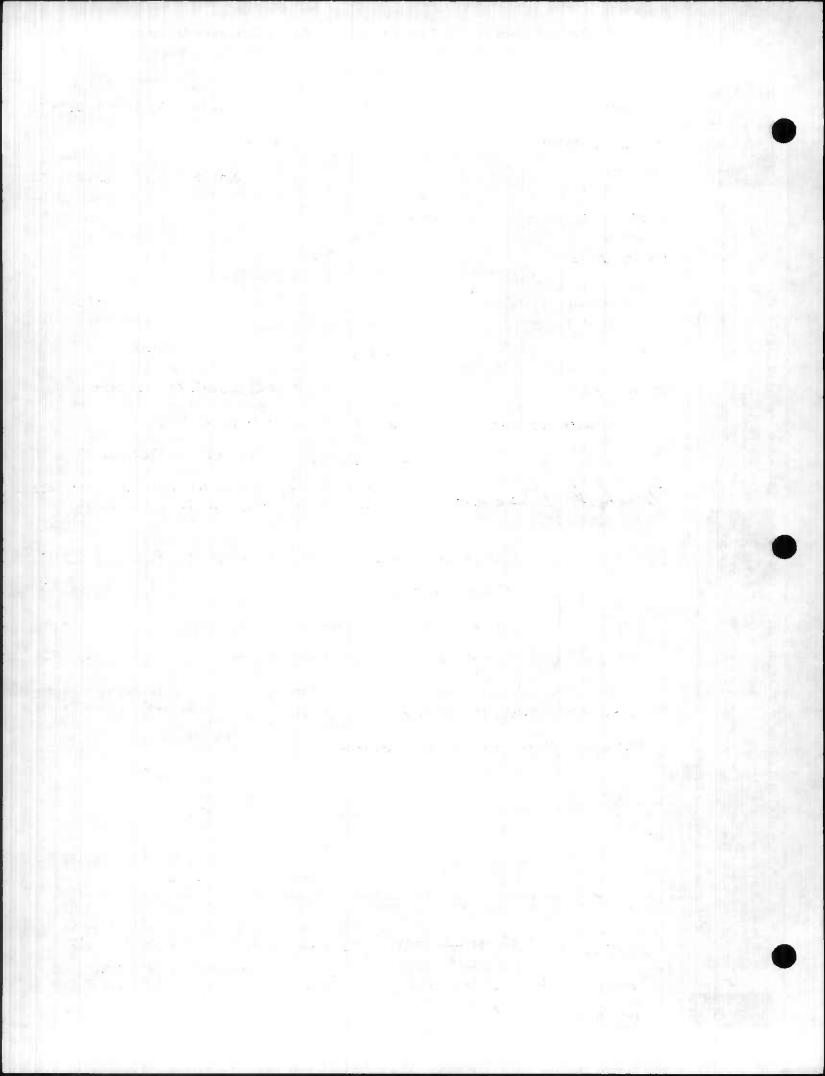
31. Dete filed (Month, Dey, Year)

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	Dharatata		1. Decedent's Name	(First, Middle, L.	est)						2. Data of Dee Month	th Day	Yaar	3. Time of Death
	Physicia: /Medica		MARGA	RET	EL:	IZABET	'H	EDGE			Decembe	0.0		3:28 AM
	Examine		4e Facility Nama (If I	not institution, gi	ve street and nu	mber)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Death	
			414 Camd					W (dada da A Vana		sbur			mico	
	Funeral Director		5. Social Security Nur 212–12–23	49	Sax 1□M 2∏ F	7. Aga (In yrs. 84	· last birthday) Yrs.	If Undar 1 Yeer Months Days		Min.	8. Data of Birth (Month, Day			lace (State or Foreign try) yland
	and w	1	Usual Rasidance of E	10b. County		10c. Ci	ity, Town or Lo	cation					10	Od. Insida City Limits
	Mary	0	Maryland	Wicom	ico		Salisbu	irv						Y□Yes 2□No
	28e	Director	10e. Street and Numl	ber				10f. Zip Code			1	0g. Citizen of	What Coun	try?
	3a o		414 Camo	len Cour	t.			2180	01			USA		
	dead	Funeral	11. Maritel Status			edent Ever In U	J,S. 13.	Wes Decedent of I f Yas, specify Cub		lgin? (Spe	cify Yes or No-	14. Rac	e - Amarica	
Maryland 21215-0020	urs a	2	1 ☐ Never Merried 3 ☐ Widowed 4		1  Yas If Yas, Gir Year or D	2 XNo		1 ☐ Yas 2 ☐ No			nican, etc.)	Specify		nite
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9	other tr	-	James Be		uge/Son	20b.	Place of Dispo	Box 66°		.ISDu	-	21803 20c. Location	City or To	wn. Stata
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Baltimore,		-	4 ☐ Donetion 5					n Cemeter  Nama and Addre	-	tv				
Ba	Departri Departri Importa eny Inju		23a. Part1. Enter the shock, or haart	11 1	A			77-77		7	Home Pr	ofessio	nal A	ssociation
	Physician /Medical Examiner	ner	Immediate Cause (F disease or condition resulting in deeth)		a. CA	PRD	or es a consec	SCUL A						Onset and Deeth  MINS
	and I-transit	Examine	Sequentially list cond	titions	b		or as a consac							1000-
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Box	attand for us	San S			<b>u</b> .									
P.O.	as that tha de igned by tha s be datached	Physician/Medical	Part II. Other signific					ndarlying ceusa gi		i.		ss 2 No		the cause of death?
of Vital Records,	law requiras that tha daath certificate be executed as been signed by the attending physician and a 2 should be datached for use as the burial-transit	completed by	CHR	ome (	6224	1100	5,	200			24a. Was a perfor		ava	ere autopsy findings allable prior to mpletion of cause death?
Re	0 - 0	E									417.9	es 2 to No		Yes 2 No
ta	cartificate rector, pa		25. Was case referre	d to medical	T				26. Piace	e of Death	(Check only or		1	
>		9	examiner? 1 ☐ Yes 2 ☑ N	0	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA O	lla a ri		ma 5 Resid		nar (Specifi	y)
0	g Physicar this		27. Mannar of Deeth	5 Dendina	28a. Data	of Injury th, Day Year)	28b. Time of Injury	28c. Inju			28d. Dascribe h			
Sio	ath. x: Aff		2 Accidant	5 Panding Invastigation	n	,	,,		]Yes 2□	No				
Division	tal or Attending P rs aftar death. al Director: Aftar t led in by tha funar.	Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could not l	208. PI908	of Injury - At h	oma, fem, str fy)	aat, factory, office			28f. Location (S City or Tow		ber or Rura	l Routa Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical	29a. Cartifiar 1 (Check only 2 one)	ertifying P	minar: On tha b	best of my knoasis of axamina nar stated.	owledge, daath ation end/or in	n occurred at tha ti vestigetion, in my	ima, data ar opinion, des	nd place, a ath occurr	and dua to tha c ed at tha tima, c	ausa(s) and m lata and place,	anner as st and dua to	tated. tha causa(s)
	To the composite of the	3	29b. Signatura and ti		2				sa number			29d. Date signe	)	
			14	earl !	V Ce	-	- W	Do	004	36	6	12/2	8/	18
	1-	1	30. Nama and addras					Print) 5	-40	8270	1885	25	200	2
	6		FRIO	- NOV	W. C6	2216	-ON 1	ND. S	22	15.	SHAY	md.	01	30/
	State	9	31. Date filed (Month)	, Day, Year)	32. R	legistrar's Sign	etura							

DHMH 16 Rev 6/95



Amended # 20 mer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

Certificate	of	Death

Reg. No:

4c. County of Death ALLEGANY

Physician
/Medical
Examiner

1. Decedant'a Name (First, Middla, Last) NOLA MARIE ELLIOTT

2. Data of Death DECEMBER

3. Time of Death

4a Facility Nama (If not Institution, give street and number)

4b. City, Town, or Location of Death CUMBERLAND

25,1998 4:50 AM

**Funeral** Director

r than "natural", or items 23e or 28e-f ahow the Medical Examiner must be northed at

Pages 1 and 2 should be filed within 72 hours after death nearl of Heelih and Mental Hygiene.
Ant: If item 27 le marked other than "natural", or itema 23 my or other traumatic avant, and who call Evanton must my or other traumatic avant, and who call Evanton must

permit. Page Department of Important: If any Injury or page.

Physician /Medical

**Examiner** 

physician and the burial-transit

attending p

been signed by the s should be detached

page 2

director

in by

certificate

this funeral

Hospital or Attanding Physician:

death.

after deat

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

altimore, Maryland 21215-0020

the Maryland

with

213-22-4533 Usual Rasidance of Decedent 10a. Stata

5. Social Security Number

7. Aga (In yrs. last birthday) 1□M 2QF 94 Yrs.

If Undar 1 Yaar Months Days

9. Birthpiace (State or Foreign

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) MAR - 16, 1904

WEST VIRGINIA

10b. County

MD

Directo

Funeral

P

Completed

Be

ALLEGANY

ALLEGANY COUNTY NURSING HOME

6. Sex

CUMBERLAND

10c. City, Town or Location

10d. Inside City Limits Yes 2 No

10e. Street and Number

11. Marital Statua

510 WELCH AVENUE

12. Was Decadant Evar in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yas, Giva X Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, etc.)

14. Race - American Indian. Black, Whita, atc. Specify: WHITE

1 Never Married 2 Married 3 Widowed 4 □ Divorced

15. Decedent's Education (Specify only highast greda completed)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)

1 ☐ Yas 2 ☒ No Specify:

16b. Kind of Businass/Industry

HOME

10g. Citizen of What Country?

U.S.A.

Elementary/Secondary (0-12) 8

College (1-4or 5+)

HOMEMAKER

10f. Zip Coda

21502

17. Father's Name (First, Middle Last)

ELIJAH VANCE

18. Mothar'a Nama (First, Middla, Meidan Sumama) PHOEBE JANE MORRAL

19a. Informant's Name/Raletionship (Type, Print)

510 WELCH AVENUE, CUMBERLAND, MD

19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) 21502

OWEN J. RICE / SON 20a. Mathod of Disposition

21. Signature of Funaral Service Licensee

1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or other place) ZION MEMORIAL PARK 12/35/98 20c. Location - City or Town, Stata CUMBERLAND, MD

CUMBERLAND,

22. Nama and Addrass of Facility
UPCHURCH FUNERAL HOME, P.A.

21502

The bockerce

202 GREENE ST., 23a. Part1. Enter the diseasa, or emplications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disease or condition resulting in deeth)

a CHRONIC OBSTRUCTIVE LUNG DISEASE Dua to (or as a consequence of):

YRS

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad events resulting in daath) Last

Dua to (or as a consaquance of):

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2☑No

1 Yes No

25. Was case referred to medical 1 Yes 2 No

27. Mannar of Death 5 Panding 1 Naturel 2 Accidant

invastigation 6 Could not be detarmined 28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of

Other: Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Describe how Injury occurred 2 No

26. Place of Death (Check only one)

MD. 21502

28a. Place of Injury - At homa, farm, straet, factory, office bullding, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicida

4 ☐ Homicide

12 Cerurying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title/of certifier

29c. License number 0-14865 29d. Date signed (Month, Day, Year)

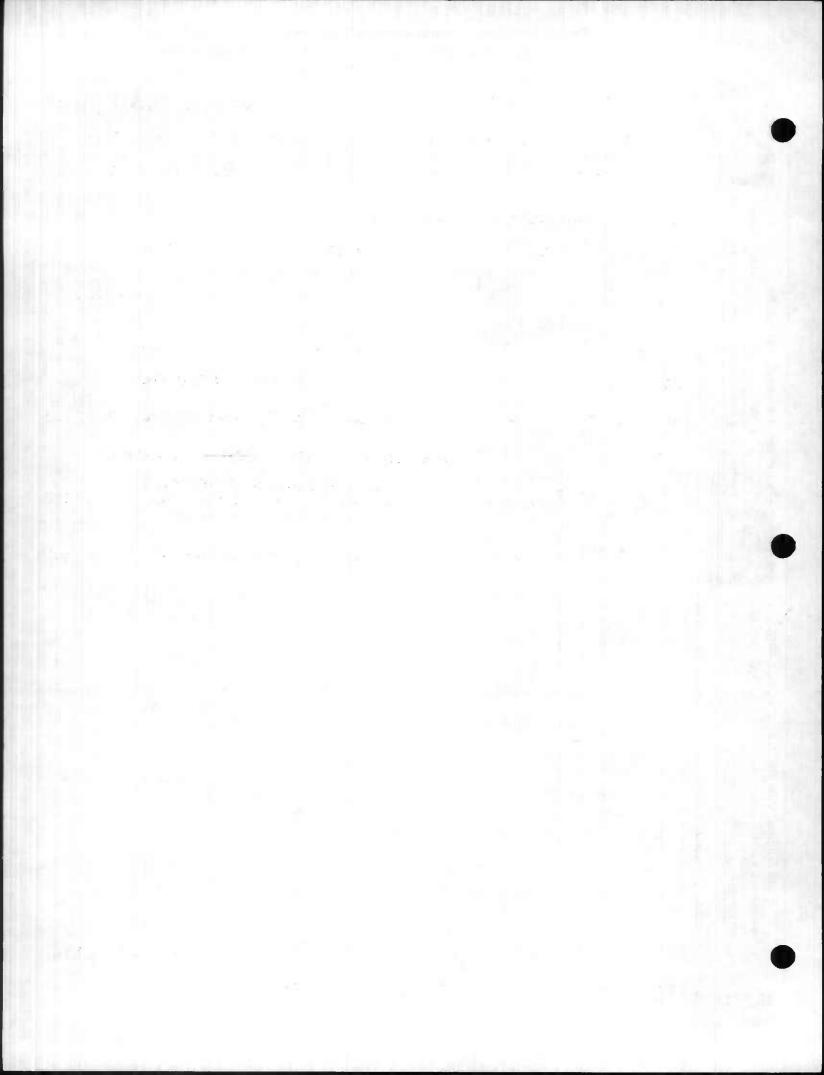
course 30. Nema and address of person who completed causa of dwth (Itam 23a) (Type, Print) BARRERA

KOBUSTIANO 31. Dete filed (Month, Dey, Year) DEC 3 0 1998

32. Registrer's Signeture Legaran

State Registrar

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death MILDRED EVERETTE December 16, 1998 4:45 PM 4e. Fecility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3512 Hepburn Court Burtonsville Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
North CAROLINA Months Deys 1□M 2XF Yrs 84 240-12-5756 Aug 24, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Vas 2 No Montgomery Burtonsville 10e. Street end Number 10f. Zlp Coda 10g. Citizen of What Country? 3512 Hepburn Court 20866 United States 12. Was Decedent Evar in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Giva Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 🗓 No Specify: Specify: BLACK 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) COSMETOLOGIST BEAUTY SALON 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) MARION HALL SALLIE FLOYD 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GAIL ROBINSON /Daughter 3512 Hepburn Court, Burtonsville, Md. 20866 20b. Plece of Disposition (Nema of cemetery, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Lightner Funeral Home Dec 21,98 Goldsboro, No.Car. 22. Neme and Addrass of Facility M859 ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020 23a. Pert1. Enfer the disasse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Finel disaesa or condition resulting in deeth) es Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ti-infarct D 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy pertension remia 1□ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth | Check only one | Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

the

signed by t

peed has

certificate

funeral

in by

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific

by

Completed

Be

10

Certification:

Medical

8

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic evant, tre Medical Exansiner must be notitled at

permit. Pages 1 and 2 should be filed within 72 hours after deeth a Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

the Menyland

1/7

10a. Stete

Director

Funeral

þ

Completed

Be

2

Examiner burial-transit Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events rasulting in daath) Last end physician s the burial Physician/Medicai 980

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Other: 4 Nursing Home

5 Rasidence 8 Other (Specify)

28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceusa(s) and mannar as stated. 29a. Certifier

Z Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatury and title of certifian

31. Dete filed (Month, Day,

27. Manner of Death

2 Accident 3 Suicide

> 29c. License number 30361

29d. Date signed (Month, Day, Year)

30. Neme and edd res of pers in yno completed cause of death (Item 23a) (Type, Print) Marger

Watter Reed Army Medical Center Wishington, DC 20015

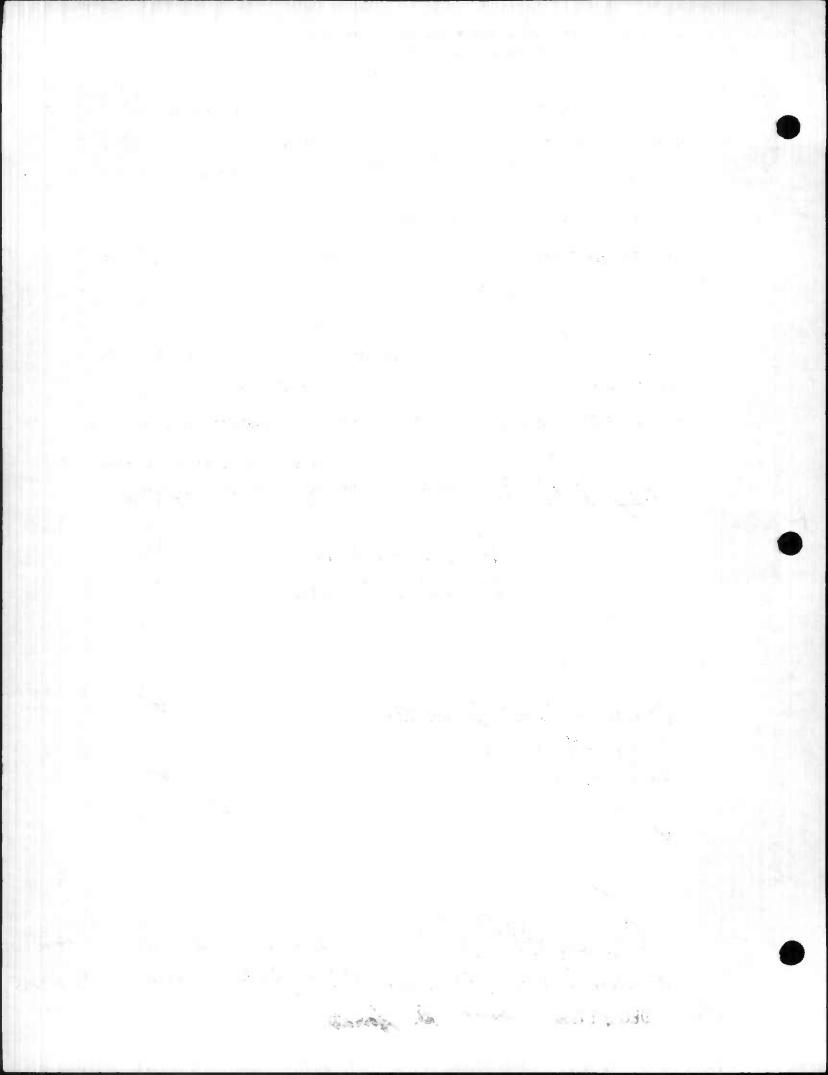
State Registrar

1 1998

5 Pending investigation

6 Could not be determined





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L		-	11	4
			U	V

and Number Hudson  Stetus  er Married 2 Me owed 4 Divorce  (Specify only high ry/Secondery (0-12) 10  Name (First, Middle 5 Fyfe  ent's Neme/Rejetion m Florin 1 of Disposition riel 2 Cremelion retion 5 Other (including the content of the content	E.  ion, give street  g & Rei	Road  Road  rint)  rint)  Road  rint)  rint)	tation Age (In yrs. Is 82  10c. City Dam  Int Ever in U,S S? ONo S: For 5+)	19b. Mailin ece of Disponentery, crei	if Under Months  cation  Jarte  10f. Zil  213  Wes Dece if Yes, specific	r 1 Year Deys  r S p Code 821  dent of H cify Cube XI No  sel Occup ork done of se retired er  Sabe me of cother plea Cen and Addre ge F de of dyin	Berlin  If Under 2 Hours  Hours  Rispente Origan, Mexican, Specify:  Betton during most  18. Mother Elizal end Number St.  See) metery ss of Facility unera	in? (Speed Puerto For Rural Puerto For R	(First, Middle Cham  Route Numb  Dete  / 28 / 98	Dey ER 25 th 4c. County Worce irth ey, Year) 25, 1916  10g. Citizen of U.S., 0- 14. Rec Bie Specifi  16b. Kind of B Homem. ber, City or Town Deep, City or Town Deep R 08 Willia Berlin, Merrest,	y of Death ester  9. Birthplace (Country) New Je  10d. Ins 15  Whel Country? A.  10e - American Induck, White, etc. 10y: White tusiness/Industry aker  10e - Town, St. 10e - T	ersey  side City Limits  § Yes 2 □ No  lien,
n Nursing curity Number 2-9628 lenca of Decedent 10b. Count land Soli and Number Hudson Stetus er Married 2 Me owed 4 Divorce (Specify only high ry/Secondery (0-12) 10 Name (First, Middle 5 Fyfe ent's Neme/Reletion m Florin to Disposition riel 2 Cremetion riel 5 Other (incrementation religion 5 Other (incrementation) religion 6 Other (incrementation) religion 7 Other (incrementation) religion 8 Other (increment	White    Complete the control of the	Road  Road  rint)  rint)  Road  rint)  rint)	tation Age (In yrs. Is 82  10c. City Dam  Int Ever in U,S S? ONo S: For 5+)	19b. Mailin ece of Disponentery, crei	if Under Months  cation  Jarte  10f. Zil  213  Wes Dece if Yes, specific	r 1 Year Deys  r S  p Code 821  Ident of Hecify Cube X No  sel Occupark done of sea retirect  r Sabe me of other pleto Cen and Addre ge F  de of dyin	Berlin  If Under 2 Hours  Hours  Rispente Origan, Mexican, Specify:  Betton during most  18. Mother Elizal end Number St.  See) metery ss of Facility unera	in? (Speed Min.)  in. (Speed M	8. Dete of Bi (Month, D Feb	Worce inth ley, Year) 25, 1916  10g. Citizen of U.S., 0- 14. Rec Ble Specifi  16b. Kind of B  Homem ber, City or Town Obbs Fe 20c. Location Deep R 08 Willia Berlin, Merrest,	9. Birthplace (Country) New Je 10d. In: 15 Whel Country? A. 10e - American Indick, White, etc. 19: White Rusiness/Industry aker 10d. In: 15 Whel Country? A. 10d. In: 15 White 10d. In: 15 Whel Country? A. 10d. In: 15 Whele Country? A. 10d. In: 15 Whele Country? A. 10d. In: 15 Whele Country? A. 10d. In: 15 Indick Country A. 10d. In: 15	ide City Limits  Q Yes 2 No  1052: ete  T  S11  px/mete all Between t end Deeth
lenca of Decedent  10b. Count  10c. Count  10c. Count  11c. Decede  11c. Decede  11c. Specify only high  10c. Tyfe  10c. Ty	white  White  12. W A A A A A A A A A A A A A A A A A A A	Road  Tes Decedent med Forces  Yes, Give eer or Detes  Apleted)  Trint)  Tel from Stete  Is thet gallsuse on sach	10c. City Dam  Int Ever in U,S S? No s:  20b. Pictor Color For ind the death ine.	Yrs.  7, Town or Lones Quantity  16e. Decen (Give liffe.)  19b. Mailin  19b. Mailin  22  B  Do not ent	Months  Docation  Jarte  10f. Zh 213  Wes Dece If Yes, spe If Yes,	rs p Code 821 dent of H deity Cube X No nel Occuppork done is retired ner s (Street Sabe me of other plea Cen nd Addre ge F de of dyin	Hours  Hours  Hours  Hispenic Original Conference of the Conference of Facility  Helion during most of the Conference of Facility  Elizal end Number of Facility  Est.  Hours  18. Mother Elizal end Number of Facility  Est.  Hours  19. Mother Elizal end Number of Facility  Europe of Faci	in? (Speeperto For Working) 's Name beth  of Working  's Name beth  of ardiac or	Feb.  city Yes or Notican, etc.)  g  (First, Middle Cham  Route Numb  Dete  / 28 / 98	10g. Citizen of U.S. According to the Specific S	New Je  10d. Inc. 18  Whel Country?  A.  ce - American Ind. ck, White, etc. by: White  dusiness/Industry  aker  me)  city or Town, St.  iver, C.  Appr. Industry  Appr. Indust	ersey  side City Limits  § Yes 2 □ No  10522  ete  T  S11  eximete  sal Between  t end Deeth
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	deleum  de reterred to medic  re	creaming investigation only 2 Medical Examiner: Course of the control of the cont	delections and a least of the l	december of the property of th	december 28 No Hospital: 1 Inpatient 2 ER/Outpetier 28 No Hospital: 1 Inpatient 2 ER/Outpetier 28 No Injury (Month, Day Year) 28 No Injury (Month, Day Year	decimal Disease    Continued   Continued	Certifying Physician: To the basi of my knowledge, death occurred at the time of manner steted.  Legand Ittle of certifier  Legan	See reterred to medical  ## Place    Place   Place   Place	Received to medical Post Received to medical Post Received to medical Post Received to medical Post Received Re	24a. We perform   24a. We perform   25c. Plece of Deeth   24a. We perform   25c. Plece of Deeth   25c. Plece	1   Yes   2   No   No   No   No   Hospital:   1   Inpatient   2   ER/Outpetient   3   DOA   Other:   4   Nursing Home   5   Residence   8   Other   No   No   No   No   No   No   No   N	1   Yes 2   No 3   Probably   Probably

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Physician 12:15 PM John Flett, III H. 4b. City, Town, or Location of Death 1998 /Medical 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Southern Maryland Hospital Clinton f Under 24 Hrs. Prince George's If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stefe or Foreign Country) **Funeral** Days 1□M 2□F Months Hours Yrs. Director 213 42 6510 59 Sept 8, 1939 Washington DC Usual Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits ehow is 23a or 28a-f ehov MD P.G. 1 ☐ Yas 2 ☐ No Director Upper Marlboro 10e Street and Number 10f. Zip Code 10g, Citizen of Whel Country? 9910 Lyndie Lane Funeral 20772 United States
14. Race - American Indian, hems: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. filed within 72 hours after Yes 27 No Never Merried 2 Merried 21215-0020 8 1□ Yes 2□No Specify: Specify. Completed by 3 Widowed 4 Divorced White Year or Deles: "natural", 16a. Decedenl's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry than Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. N/A 8th None/Disabled permit. Pages 1 and 2 should be file.
Department of health and Mental Hygh
Important: If them 27 is marked
any injury or other re-Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be John H. Flett Rosalie T. King 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Rosalie Flett (MOTHER) 10911 Wharton Drive, Upper Marlboro, Md 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele 1 Burial 2 Compation 3 Removal from State 4 Donation 5 Other (Specify) Dec 21, 1998 Lee Crematory Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on perh line. Approximete Interval Between Onset and Death **Physician** /Medical 5 DAYS Immediate Cause (Finel HEMIDLEGIA diseese or condition resulting in deeth) Examiner Examiner LTIPLE INTRACEREBRAL Sequentially list conditions, if eny, leeding to immediate cause. Enfer Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Attending Physicien: The law requires that the death certificate be exec Box 68760. Physician/Medicai the Due to (or es e consequence of): for use Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No POLYCYTHEMIA Be Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 a KINo 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No this 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending within 24 hours efter death. To the Funeral Director: A 1 ∏ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 8 Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 9 29c. License number 29d. Dele signed (Month, Day, Year) 29b. Signature and title of certifier you chad twons 50653 12-18-98 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) SURANA 7501 SURRATTS ROAD CLINTON. M.D.

Registrar **DHMH 16 Rev 6/95** 

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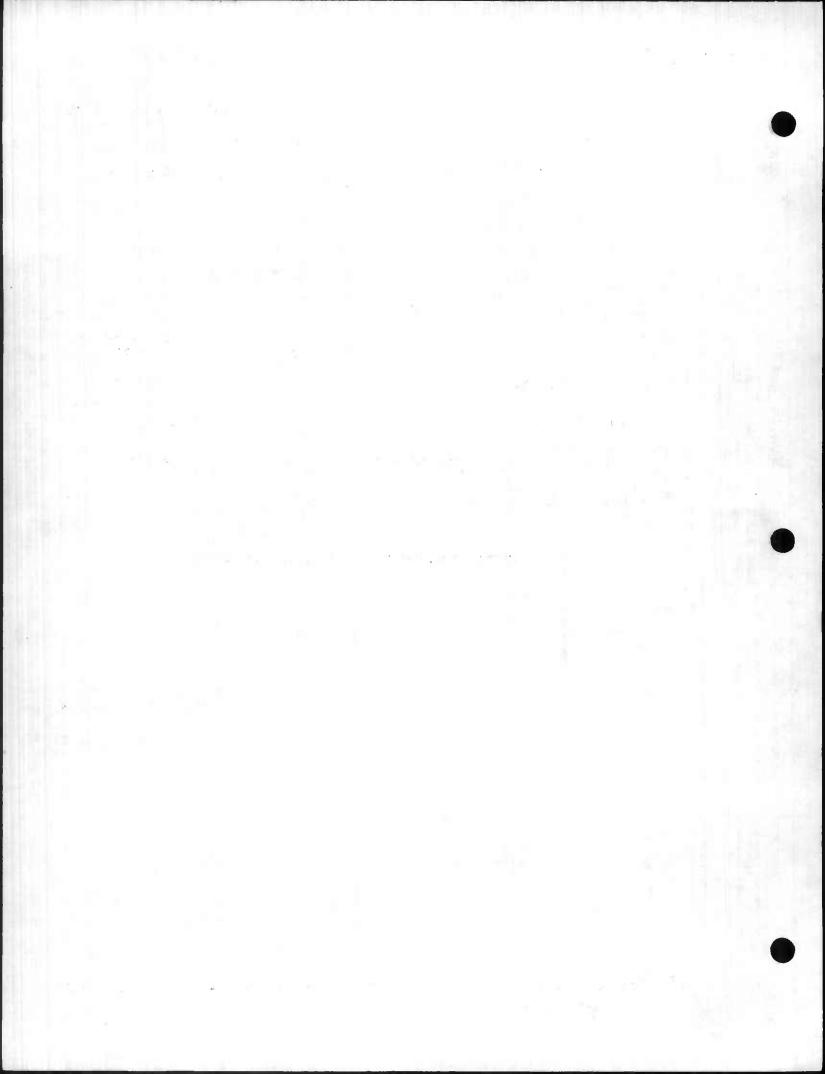
31. Date filed (Month, Day, Year)

32. Registrerts Signeture

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Part II. Other significant conditions	contributing to death	but not resul	ting in the un	derlying cause g	iven in Part I.				A 4
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1√2 Yes 2 No	Hospital: 1 ☐ Inpat	ient 21 E	R/Outpatient	3□ DOA O	ther: 4 Nursing Ho	ma 5 Resid	dence 6 Oth	nar (Specify)	
27. Manner of Death  1X Natural 5 ☐ Pending 2 ☐ Accident invastigetic	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	28c. Inju Wo	ary at ork? ]Yes 2 ☐ No	28d. Describe I	how injury occur	rred	
Z C / NOCIOON	be 28e. Place of Ir	ijury - At hon tc. <i>(Specify)</i>	na, farm, stre	et, fectory, office		28f. Location (S City or Tox	Street and Numb vn, State)	ber or Rural Rou	te Number,
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Marital Status 12. Was Decedent 14. Was Decedent 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 12)  17. Father's Nama (First, Middle, Last)  Thomas Leonard Ford, Sr.  19a. Informant's Name/Relationship (Type, Print)  Alma King Ford / Wife  20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee 12. Sequentially list conditions shock, or heart failura. List only one date on asch 12. Sequentially list conditions, if any, leading to immediate cause (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause (Final disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death 12. 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Sex 1 New Factor Dates: 1961-65  17. Father's Name (First, Middle, Last)  Thomas Leonard Ford, Sr.  19a. Informant's Name/Relationship (Type, Print) Alma King Ford / Wife  20a. Method of Disposition 1 Marial 2 Cremation 3 Removal from State 4 Constitution 5 Cother (Specify)  21. Signature of Funeral Service Licensee 22. Maria Burial 2 Cremation 5 Cother (Specify)  23a. Part1. Enter the disease, or complications that caused the death. Do not enteresting in death) Last  1 Due to (or as a consequence of the constitution of the print)  Arteriosclerotic Constitution of the printy of the	As Facility Nama (if not institution, give street and number)  Calvert Memorial Hospital  5. Social Security Number 219 26 9868  1	46. City, Town or Location Calvert Memorial Hospital Social Security Number 6. Sex 11 M 2 F 7. Age (in yrs. list birthday) 19 26 9868 Usual Residence of Decedent 10s. State 10b. County Maryland Calvert  Owings  10c. City, Town or Location Waryland Calvert  Owings  10s. Street and Number 143 West Mt. Harmony Road 11. Marital Status 11 Never Married 2 Married 12 Married 13 Was Decedent Ever in U.S. 14 Was Decedent Ever in U.S. 15 Necedent's Education (Specify) only highest grade completed) 16 Never Married (Specify) 17 Septiment Name (First, Middle, Last) 17 Thomas Leonard Ford, Sr.  19a. Informant's Name Relationship (Type, Print) Alma King Ford / wife 20a. Method of Disposition 18 Burial 2 Circeration 3 Removal from State 4 Donation 5 Cibrio (Specify) 21. Signature of Funeral Service Licensee  All Calvert  Owings  10s. City, Town or Location (Owings) 10s. Was Decedent of Hispanic Origin? (Spings) (City Specify) 11 Was 2 Doo (Owings) 12 Was Doo (Owings) 12 Was Doo (Owings) 13 Was Doo (Owings) 14 Was Doo (Owings) 15 Was Doo (Owings) 16 Was Boo (Owings) 16 Was Boo (Owings) 16 Was Boo (Owings) 16	THOMAS LEONARD FORD, Jr.  a Facility Name (if not institution, give sines and number)  Calivert Memorial Hospital  S. Social Security Number  19 26 9868  12 M 2 F 7. Age (in yrs. last beheday)  10s. State  10s. State  10s. State  10s. County  Maryland  Calvert  10s. State  10s. Sta	THOMAS LEONARD FORD, Jr.  \$   Eccember   14,	THOMAS LEONARD FORD, Jr.  Calvert Memorial Hospital  Security Number Calvert Memorial Hospital  Security Number Security Number Security Number Calvert Memorial  Security Number Calvert Memorial  Security Number Calvert Memorial  Security Number Calvert Memorial  Security Number Calvert  Morths  Security Number Calvert  Morths  Security Number Calvert  Morths  Security Number Calvert  Owings  100. Clay, Town or Location Ow

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Veer **Physician** 14, Lydia Fuller Dec. 1998 3:45AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Pineview Nursing Home Clinton If Under 24 Hrs. Prince Georges ff Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiaca (Stata or Foreign Country) Min 1□M 2QF Months Days Hours Yrs July 15, 1918 Virginia 579 28 5885 Usual Rasidanca of Decedan 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes XX No Director MD P.G. Clinton 10e. Street end Number 10f. Zip Coda 10g, Citizen of What Country? 8600 Mike Shapiro Drive 20735 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva XX Yeer or Detes: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Maritel Status 14. Rece - Amarican Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XXIo Specify: 3 ☐ Widowed 4 ☐ Divorced þ White Completed 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Susinass/Industry 15 Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8th 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Be Emma Hill George T. Van Pelt 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Linda Fuller (Daughter) Maryland 20874 18964 Grotto Lane, Germantown, 200. Location - City or Town, Steta atary, cramatory or other place) Dec 17, 1998 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 1 Burial 2 Cramation 3 Ramoval from Stata Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Nama and Addrass of FacilityLee Funeral Home, Inc 6633 Old 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Approximate Approximata Intarval Between Onset end Deeth Immediata Causa (Final disaasa or condition resulting in deeth) me - URELLIA SEADTIC CANDIBUAGU Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury SZASZX that Initiated avants Due to (or es e consequence of) rasulting in death) Last 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed TO Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No P 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Thomicide

death certificate be executed attending physician and for use as the bunal-transit Box 68760. ed by the a P.O. signed t Records, been s The law certificate has page 2 Division of Vital Physician: After this funeral or Attending death. eral Director: A after To the Hospital within 24 hours a To the Funeral E pletely

**Funeral** 

Director

Items 23a or 28a-f show ingrement be notified at

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the Medical

the Maryland

death

72 hours after

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2 should be f and Mental H is marked

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum page.

**Physician** 

/Medical

Examiner

Maryland 21215-0020

1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data end place, and due to tha cause(s) end mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signatura and titla of certifier 29c. Licansa number 30. Nama and odrass of person who complated causa of deeth (item 23a) (Type, Print) 12070 CULSOY QUD LINE

32. Registra/s Signatura

CENTER WALDONF, Md. 20602

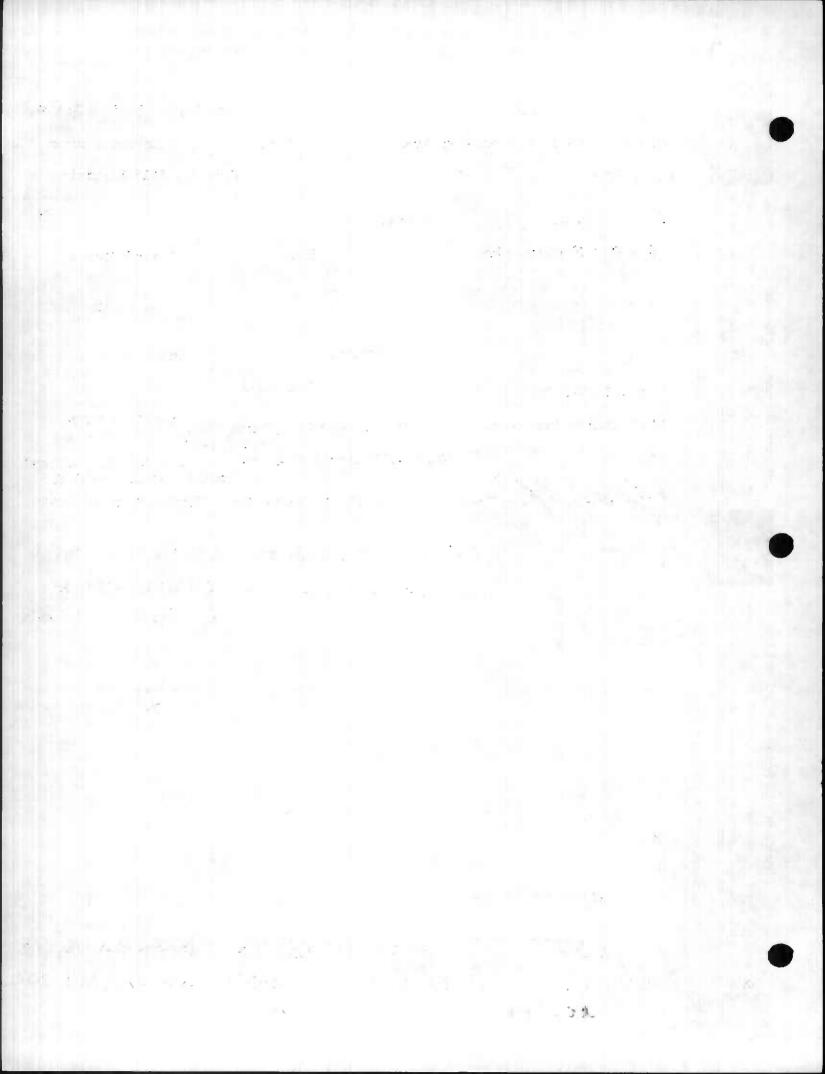
29d. Data signad (Month, Day, Year)

State Registra

29a. Cartifian

31. Data filed (Month, Day, Year)

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** WILLIE JOE FARRIS December 18, 1998 11:50 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner FORT WASHINGTON HOSPITAL PRINCE GEORGE'S FT. WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5 Social Security Number 6 Sex 7. Age (In vrs. last birthdev) Birthplece (State or Foreign Country) **Funeral** 11 M 2□ F 51 Yrs. Director 419-60-4283 APRIL 18, 1947 DOLOMITE, AL Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r 28a-f show Yes 2 No MARYLAND PRINCE GEORGE'S FT. WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23s or 9516 FORT FOOTE RD. 20744 IISA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Hem 27 Is marked other than "natural", or Hems 23. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Stetus Bleck, White, etc. 1 Yes 2 No if Yes, Give Yeer or Detes: 1☐ Never Merried 2☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify. BLACK Py 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Businass/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 2 YRS. Elementery/Secondary (0-12) DIRECTOR OF FOOD SERVICES MARRIOTT CORP -PVT. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be LUCIOUS MEALING ERNESTINE MALONE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FT. WASHINGTON, MD 20744 BARBARA H. FARRIS 9516 FORT FOOTE RD. 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place)
FT. LINCOLN CEMETERY 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) permit. Page Department of Important: If any Injury or once. = 8 12-23-98 BRENTWOOD, MD 22. Name end Address of Feclity 21. Signeture of Funerel Service Licensi MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MD 23a. Pert1. Enter the diseese, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onaet end Deeth **Physician** /Medical immediate Cause (Final 6 months Glioblastoma disease or condition resulting in deeth) Examiner Due to (or es a consequenca ot): Examiner that the death certificate be executed physician and is the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of) attending pl Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by the 1 Yss 19 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? s certificate has director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes a No this funeral 27. Menger of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Metural death. 1 Yes 2 No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or At 24 hours after d Funeral Direct 4 | Homicide 24 hours Funeral etely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

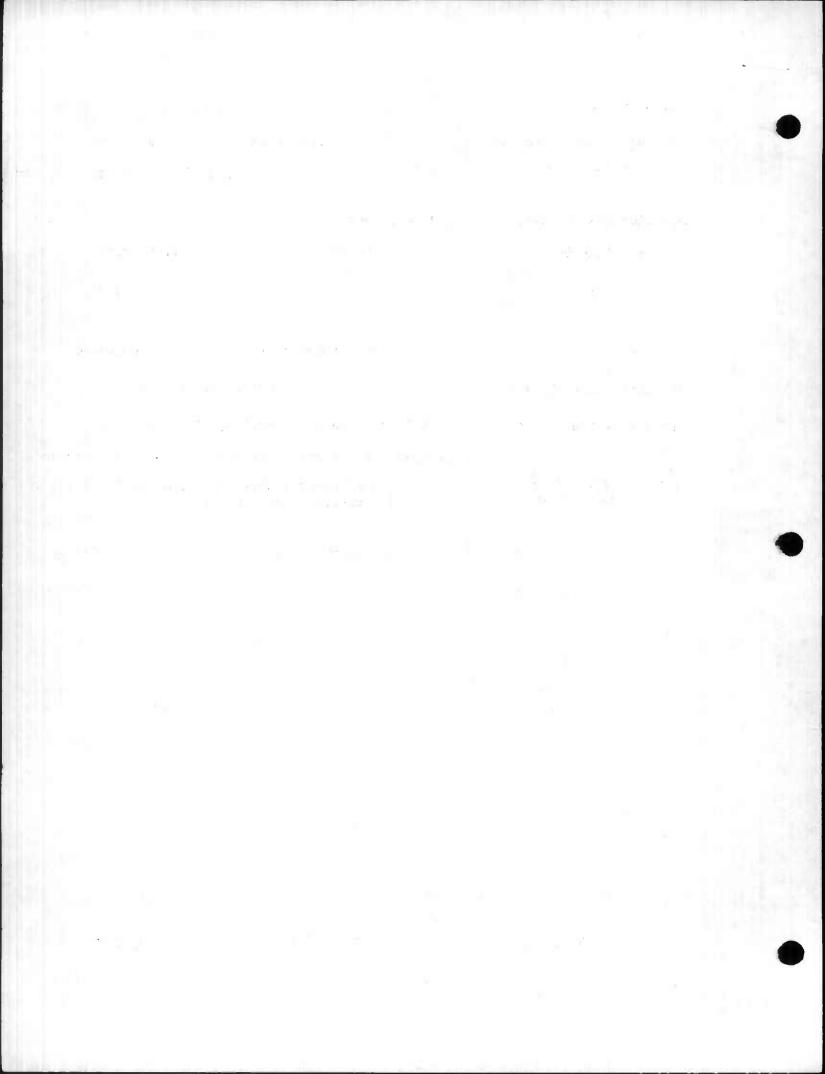
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To me 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9 D30296 8 30. Name and address of person who completed cause of death (item 23e) (Type, Print) DEBORAH THOMPSON MP MARLOW HIS MD M. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture DEC 2 1 1998

Registrar

					ertificate of	Health and N Death		Reg. No.	O H	1108		
Physiclan /Medical		Decedent's Nama (First, Middla, Last)     Commodore Edward Giffin					2. Data of Dec	Dey	Yeer 98	3. Tima of Death 0338		
Exami		4a. Facility Name (If not institution, give street end number)  4b. City, Town, or Location of Deeth  4c. County of Death								3330		
Funeral Director		Washington County Hospital  5. Sociel Security Number 220-18-3390  6. Sex 1⊠ M 2□ F  7. Age (In yrs			rs. last birthdey)   If Under 1 Year   If Under 24   Months   Deys   Hours   M							
and land	Completed by Funeral Director	Usuei Residence of Decedent  10a. Stete 10b. County								Od. Inside City Limits		
Mary		West Virginia Berkeley Falling Waters						1 □ Yes 2 No				
ath with the 23e or 28		100. Street and Number 1003 Williams Drive			10f. Zip Code 25419			10g. Citizen of What Country? United States				
within 72 hours effer death with the Maryland jiens. Than "natural", or itame 23s or 28s-f show the Medical Examiner must be incitified at		11. Marital Status 1 ☐ Nevar Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Nevar Married 2 Merried Armed Forcas?  1 Yes 20 No			U,S. 13. Was Decedent of Hispenic Origin? (Specify Yes of If Yas, specify Cuban, Mexican, Puarto Rican, atc.  1 □ Yas 2 ☒ No Specify:			No- 14. Rece - American Indian, Black, White, etc.  Specify: White			
within ena. than		Eiementery/Secondery (0-12) College (1-4or 5+)			duning most of working							
事を発光	BeC	17. Fether's Name (First, Middle, La	st)			18. Mother's Nam	ne (First, Middle,	Meiden Suman	10)			
should nd Mer marke	To						a Virginia Myers					
		19e. Informent's Neme/Reletionship  Ardella Giffin	(Type, Print) (Wife)			nt and Number or Rui						
Page nent o ant: If I		Ardella Giffin (Wife)  20a. Method of Disposition  1 \times Burlai 2 \times Cremetion 3 \times Removel from State  4 \times Donation 5 \times Other (Specify)  1003 Williams Drive Falling Waters WV 25419  20b. Pleca of Disposition (Name of cemetery, cremetory or other plece)  4 \times Donation 5 \times Other (Specify)  20c. Location - City or Town, State  12-30-98 Sharpsburg, Maryland							wn, Stete			
permit. Pages 1 as Department of Hea Important: If Item i any injury or othe		21. Signature of Funeral Strvice Licrosee  22. Neme end Address of Fecility Osborne Funeral Home 425 South Conococheague S Williamsport, Maryland 21795										
Physiclan /Medical Examiner	Medical Examiner	23a. P Int. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate intervel Between Onsat and Deeth  Immediate Ceuse (Finel disease or condition resulting in deeth)  Due to (or es a consequence of):  Dulur or or yellow or proximate intervel Between Onsat and Deeth  Pulur or or yellow or							intervel Between			
		7555	Duly	Due to (or es a cons	equence of):				1	Ven.		
ician: The law requires that tha death certificata be assecuted cartificata has been signed by the attending physician and rector, page 2 should be detached for usa as tha burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inlitted events resulting in death) Last  Due to (or es a consequence of):  c.  Due to (or as a consequence of).										
	Physician/M							23b. Did tobacco use contribute to the cause of death?				
	by Phys	Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.						1 Yes 2146 3 Probably 4 Unknown				
	Completed						24e. Was e perfor		ava	re autopsy findings lileble prior to npietion of cause leeth?		
							1 🗆 Y	es 2 No	10	Yes 20 No		
Physician: this cartificant	Certification: To Be	25. Wes case refarred to medical exeminer?  1 ☐ Yes 2 ☐ No	eminer? Hospital: Other:						seck only one)  5 ☐ Residence 6 ☐ Other (Specify)			
tending death. tor: After the fune		27. Menner of Deeth  1 Neturel 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28e. Dete of Injury (Month, Day Year) 28b. Tima of Injury M		of 28c. inju	ry et ork? ] Yes 2 No	28d. Describe how injury occurred					
<ul> <li>Hospital or Attanding</li> <li>24 hours after death.</li> <li>Funeral Director: After letely filled in by the fune</li> </ul>		4 ☐ Homicide determine	building, etc	building, efc. (Specify)			281. Location (Street and Number or Rural Route Number, City or Town, State)					
n 24 hours and Funeral filed pletely filled	Medical	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner stated.							ated. the ceuse(s)			
To the I		29b. Signeture and titla of certifier			29c. Licansa number			29d. Dete signed (Month, Day, Year) 12/27/98				
		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  ABOUL WALTER UP 12821-OAK Hill AVE. HAGERSTOUR. MD 21742										
Sta Registr		31. Dete filed (Month, Dey, Yaer) DEC 2 8		r's Signeture	9. Space	KS						

DHMH 16 Rev 6/95

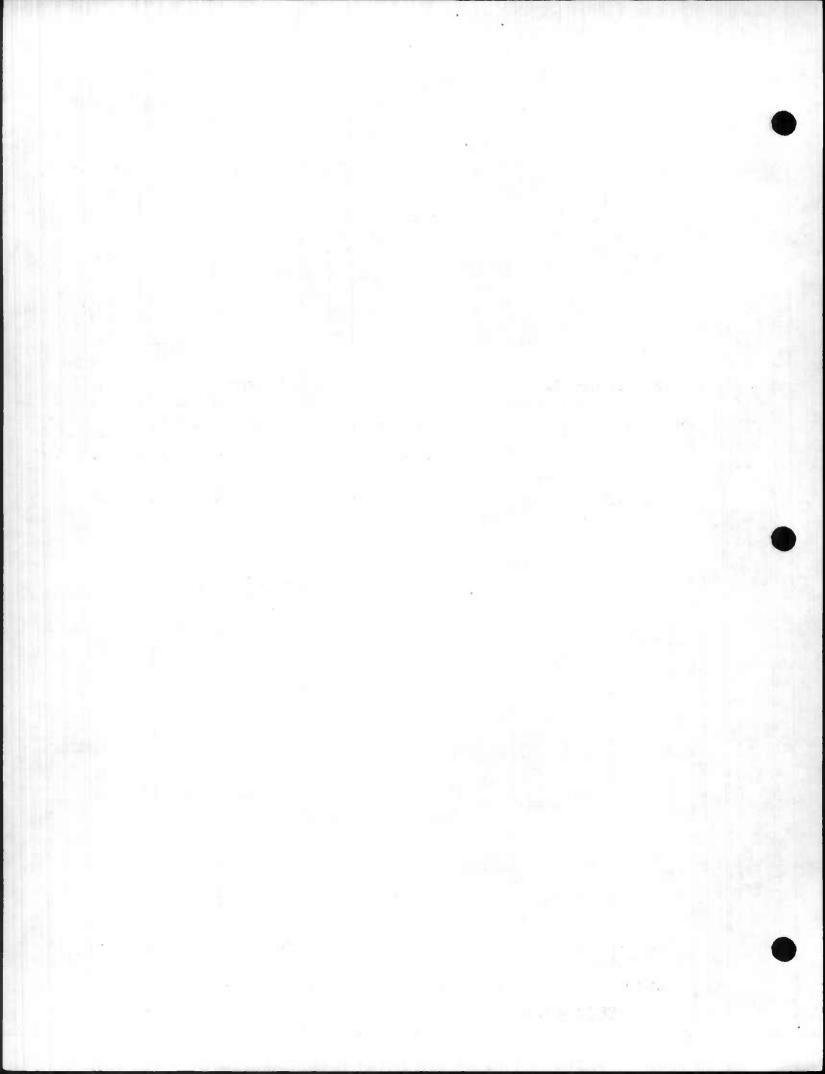
Giffin, Commodore Edward



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State of Maryland / Department of Health and Mental Hygiene 8	0	-
Cartificate of Death		

			Ce	rtificate of	Death		Reg. No.		
	1. Decedent'a Nama (First, Middle,	Last)				2. Date of D	Death	Vest	3. Time of Death
Physician /Medical	Isabel	C.		GUM		Month Dec.	25, 1998	Yeer 3	4:40PM
Examiner	4e Facility Name (If not institution,				4b. City, Town,	, or Location of Dec	ath 4c. Count	y of Death	
	Salisbury Cent	er: Genesis El	lderCare	,	Salisb	ury, Md.	Wicom	ico	
Funeral		6. Sex 7. Aga (/n	yrs. last birthday)	If Under 1 Yea	r If Under 24	Hrs. 8 Date of E	Birth	9. Birthpla	ace (Stata or Foreig
Director	030-28-7697 Usual Residence of Decedent	1□M 2MF 84	Yrs.	Months Day	s Hours	Min. (Month, I	Day, Year) -1914	DAGSE	BORO, DE.
	10a. State 10b. County	100	. City, Town or Lo	ocation				10	d. Insida City Limits
or 28e-fat be notified Director	DE SUSSS	D. D.	AGSBORO						WYas 2□No
within 72 hours after death with the Meryland then "natural", or items 23s or 28s-1 show to Medical Estimate must be notified at ompleted by Funeral Director	10e. Street and Number  MAIN STREET			10f. Zip Code 1993			10g. Citizen of	U.S.A.	
r Hame 23anin	11, Meritel Stetus	12. Wes Decedent Ever Armed Forcas?	in U,S. 13.	Wes Decedent of	Hispanic Origin	? (Specify Yas or Nuerto Rican, etc.)	No- 14. Ra	ce - America	
al, or here 23s or 28s-1 show Engineer must be notified at by Funeral Director	1 Nevar Merried 2 Marrie 3 Dividowed 4 Divorced			1 ☐ Yes 2 ☐ KN		oorto rican, etc.)	Specia	ock, White, e	
ygiene. ygiene. r. fre Medical En. Completed by	15. Decedent's		16a. Dece	dent's Usual Occ	upation		16b. Kind of E		
ple on	(Specify only highast Elementacy/Secondary (0-12)	College (1-4or 5+)	lite.	kind of work don DO NOT use retir	red)	working			
	12		ST	ORE MANA	AGER		CLOTHI	NG	
TES D	17. Fathar's Nema (First, Middle, Li	nst)			18. Mother'a	Neme (First, Midd	le, Maiden Suma	ma)	
Mental Mental artic ev	FRANK J. CHAND	LER			ANNIE	CAREY			
Pull	19e. Informent's Name/Relationshi	p (Type, Print)	19b. Maili	ng Address (Stree	et and Number o	r Rural Route Num	ber, City or Town	, Stata, Zip (	Code)
- N -	FRANK M. GUM / S	ON	RT 2	BOX 46	DELMAR.	DELAWAR	F 19940		
III	20a. Method of Disposition		b. Plece of Dispo			Date	20c. Location	- City or Tow	vn, State
0 = k	1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Denation 5 ☐ Other (Spe	8 FRANK	FORD,	DELAWARE					
Department important: I amy Injury o	21. Sign sture of Fine al Service Li	Conses	M	2. Neme end Add ELSON FU	NERAL S				al male
_	23a Part I Enter the disease or or	omplications that caused the				ET, FRAN			
	23a. Pert1. Enter the disease, or or shock, or haert feilura. List or	nly one cause on each line.	Jeen. Do not em	lei lile mode ol oj	ring, such as car	diac or respiratory	arrest,		Approximate Intarval Between Onsat and Death
Physician /Medical	Immediate Course (Charl	67							Orisat and Death
Examiner	Immediate Cause (Finel diaeasa or condition rasulting in death)	a Culay	ala	~					400-
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physician and s the burial-transit edical Examiner	Sequentially list conditions,	Dua	to (or as a consec	quence of):			1	1	
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physicians the bu	thet initiated events rasulting in death) Lest	Dua t	o (or as a conseq	quence of):					
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JU 07						24a. We par	es an autopsy rformed?	com	re autopsy findings llable prior to apletion of cause eeth?
page 2 s						45	- A - A		
tificate for, pa	On Miles						]Yes 2□No	10	Yea 2 No
certificate rector, pag	25. Was case referred to medical examiner?	Hospitel:		_ 10	ther	Death (Check only			
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h. After funer tlon:	27. Menner of Death 1 ☑Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Day Yea	r) 28b. Time of Injury	W		28d. Describ	e how injury occu	rred	
or deeth.  Ctor: After by the fune  Ification	2 ☐ Accident invastiga 3 ☐ Suicide 6 ☐ Could no			M 1[	Yes 2 No				
EXE T	3 Suicide 6 Could no 4 Homicide determin		At home, farm, str ecify)	reet, fectory, office	9	281. Location City or 7	(Street end Num own, Steta)	ber or Rural	Route Number,
within 24 hours a Yo the Funeral I completely filled	(Check only 2 Medical Ex	Physician: To the best of my taminer: On the basis of exam	knowledge, death	n occurred at the vestigation, in my	time, date and p	lace, and due to the	e cause(s) and m	anner as sta	ated. the cause(s)
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-011	0//	11/		I	29349		14	20/	0
-	30. Name and address of person wi	no completed cause of deeth (	Item 23a) (Type,	Print)				1	
5	WILLIAM ROBINS, M	1.D., 1104 HEAL	THWAY DE	R., SALISI	BURY, ME	. 21804			
State	31. Dete filed (Month, Day, Year)	32. Registrer's S			-				
Registrar	DEC 2 9	1998 Dene	me 19	las	11				

DHMH 16 Ray 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Pay 1998 James Warren Guy 4:16 p.m. 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1■M 2□ F Yrs 213-14-0302 80 January 3, 1918 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ■ No Maryland St. Mary's Loveville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28220 Point Lookout Road 20656 United States 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritei Stetus 1 ■ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Operator General Store 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Warren Guy, Sr. Estelle Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 196, Loveville, Maryland 20656 Theresa S. Guy, Wife 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) St. Joseph's Cemetery 12-21-98 Morganza, Maryland 21. Signature of Funeral Servi 22. Name end Address of Facility Brinefield Funeral Home, P.A. 22955 Hollywood ROad, Leonardtown, MD 20650 Brinsfield, JR. dward N. M00052 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy 1LYS ZENO 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1. Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 1-Neturel

Physician /Medical Examiner

for

signed by the e

should l

certificate has b irector, page 2 sl

After this funerel

after death. Director: Aft

24 hours after Funeral Dire letely filled in b Hospital

To the Vithin 2

3

Box 68760,

Division of Vital Records,

or Attanding Physician:

GUY, JAMES

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel hygiene. Important: if Itam 27 is merked other than "natural" any injury or other traumatic averages.

Examiner death certificate be executed physician and s the burial-trans 88 esn

p

Completed

Be

To

Certification:

edicai

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

25. Was case referred to medical examiner?

5 Pending

28a. Dete of Injury (Month, Day Year) investigation 6 Could not be

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

D23634

December 21, 1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Adinath Patil 31. Date filed (Month, Day, Year)

DEC 2 1 1998

32. Registrer's Staneture

6+1 NB State Registrar

DHMH 16 Rev 6/95

1 Yes 2 No 27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

28b. Time of Injury

28c. Injury at Work? 1 Tyes 2 □ No

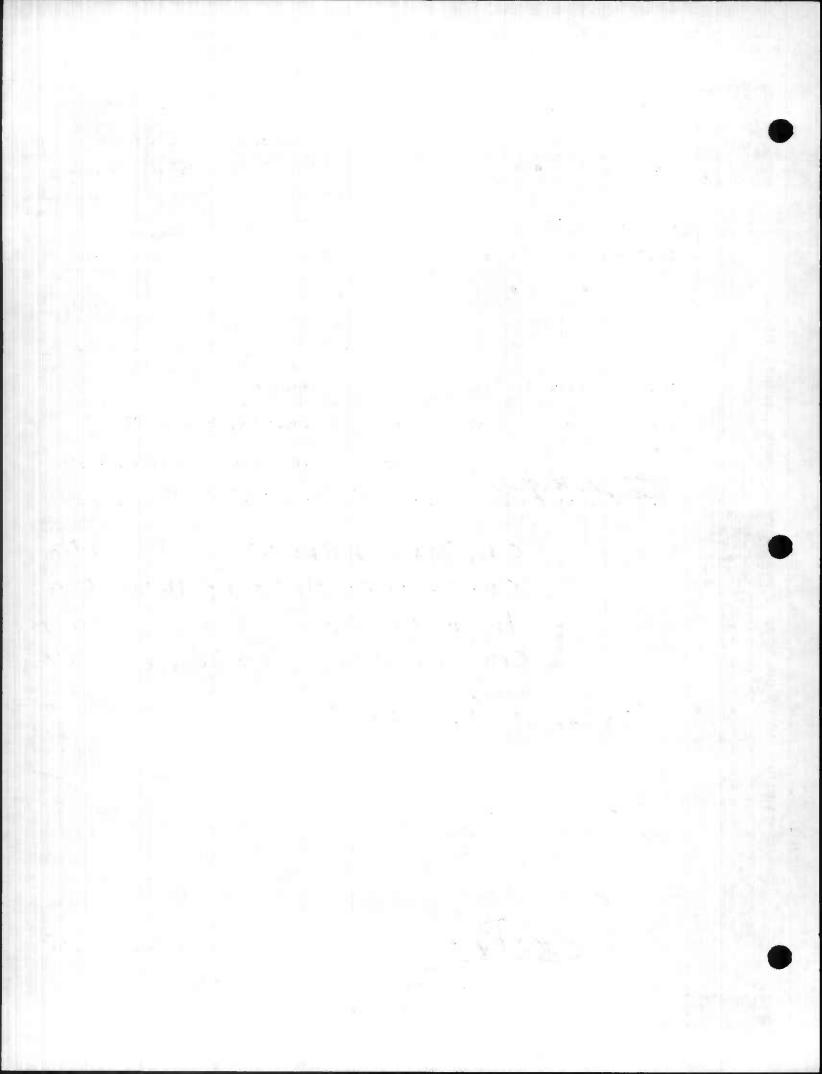
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20619

Bean Medical Center California, MD souls



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month Dey December 26, **Physician** 1998 1:30 AM Anne Ella /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 38320 Point Breeze Road Colton Point St. Mary's If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours Min. 1□M 2X F 219-58-9688 Yrs. 69 February 6, 1929 Washington D.C Director Usuel Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or hems 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo St. Mary's Colton Point Maryland 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number U.S.A. 38320 Point Breeze Road 20626 death Funeral 14. Rece - American Indian, 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 XNo Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Grace Marie Bailey Thomas F. Kennedy 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O.Box 131, Colton Point, MD 20626 Glenn G. Gass/Son other t 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from Stete Injury or Department of Important: If any Injury or 12/28/98 Bushwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart Cemetery 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) **Examiner** Examiner physician end the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by ti 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy hes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home AesIdence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state(s). 29a. Certifier Medical 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier

DHMH 16 Rev 6/95

State Registrar 30. Neme and eddr

31. Dete filed (Month, Day, Year)

person who complete cause of the th (ttem 23a) (Type, Print)

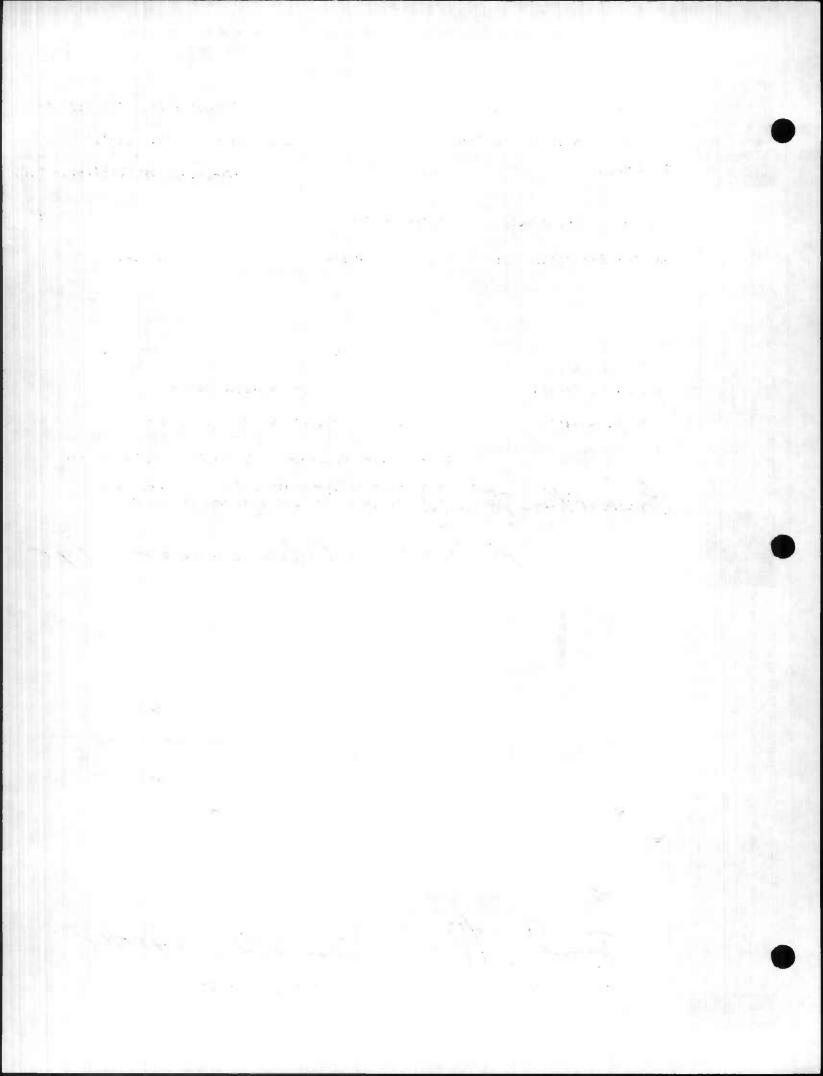
32. Registrer's Signeture

Leonardtown, MD 20650

David Allen, MD

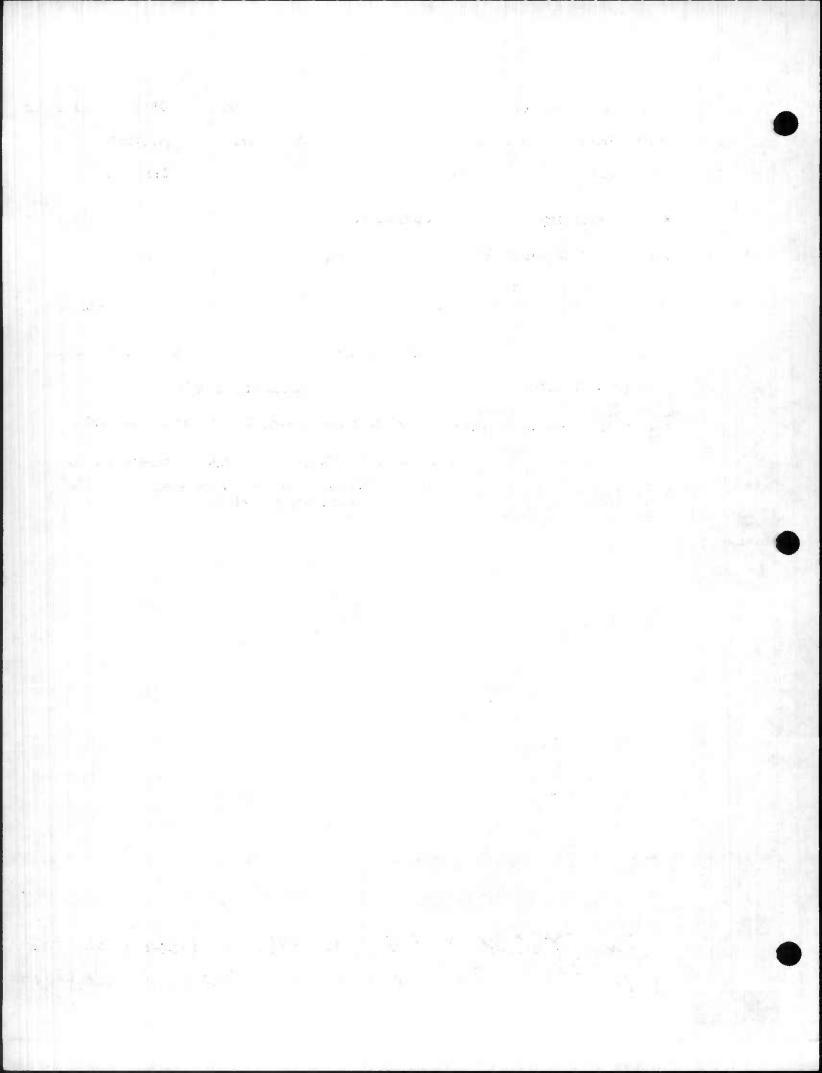
Division of Vital

Baltimore, Maryland 21215-0020

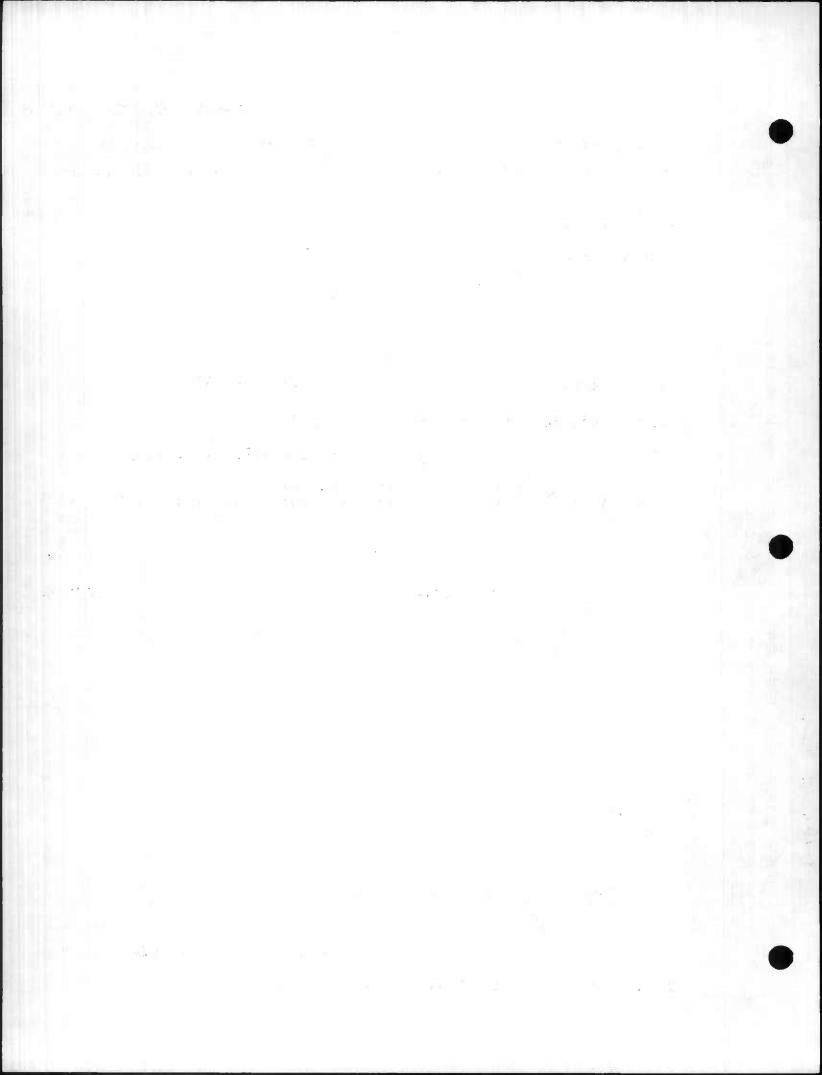


State of Maryland / Department of Health and Mental Hygiene O

						Certificate o	f Death		Reg. No.	43	6-
ı	Physic	ian	Decedent's Nama (First, Mid					2. Data of De Month		Yeer	of Death
٠,	/Medi	cal	GORDON B.				41. O'4. T-	Dec.			44 am
	Exami	ner	4a. Facility Name (If not institut	NURSING HOME	•		4b. City, Town, or				
-	-		5. Social Security Number		ga (In yrs. lest bii	thday) If Undar 1 Yes	CUMBERI ar If Under 24 Hrs		ALLEG		O. P. W.
	Funeral Director		214-07-5550 Usual Residence of Decedent	1MM 2□ F	85	Yrs. Months Day			15, 1913	9. Birthplaca (Steta Country) PA	1 o <i>r Foreig</i> n
	fand m		10a. Stata 10b. Coun	ty	10c. City, Tow	n or Location				10d. Insida	City Limits
	the Marylar 28a-f show	tor	MD Alle	egany	Cu	mberland					es 2 No
	or 284	Director	10e. Street and Number			10f. Zlp Code			10g. Citizen of Wh	nat Country?	
	a 23a o	erai D	523 1/2 E. O			215			USA		
21215-0020	s 1 end 2 should be filed within 72 hours after death with the Maryland Health end Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-4 show other traumatic event, the Medical Exameter must be ricitized at	by Funeral	11. Marital Status  1 Nevar Marriad 2 Ma  3 X Widowed 4 Divorce	If Yes Give	? No	13. Was Decedent of If Yes, specify Cu		specify Yas of No rto Rican, etc.)	Specify:	- Amarican Indian, , White, etc. White	
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21	wed w	Con	12		Ma	il Carrier			U.S. P	ostal Dep	pt.
Maryland	2 should be filed within one Mental Hygiene. Is marked other than reumatic event, the M	Be	17. Father's Name (First, Middle						, Meiden Sumeme,	1	
3	i Men I Men merka	P	Joseph H. G					e M. (Te			
Mai	12 st h end is rr		19e. Informent's Name/Relation Theresa Niland	nship <i>(Type, Print)</i> ——granddaugh	ter 19b	. Malling Address (Stre					
	1 end Health em 27 ther tr		Kathleen Nilan	dgranddaugl	nter	821 Kinkad		Falls (			
Baltimore,	permit. Pages 1 end 2 should be filed Department of Health end Mental Hygis Important: If item 27 is marked other may injury or other traumatic event, any folds.		1 Burlai 2 Cremation			Disposition (Name of ry, cremetory or other p				ity or Town, State	
Ħ	it. Parturent		4 Donation 5 Other		St. M	ary's Ceme		12/29	Cumber:	land, MD	
Ba	Departi Importi any inj		21. Signature of Funeral Service	A J Jan	rodli	Scarpe Cumber	ress of Fecility Lli Funer Land, MD	cal Home 21502	, P.A.		
			23a. Part1. Enter tha disease, shock, or heart failure. Lis	or complications that cause st only one cause on each l	d the daath. Do i				rrest,	Approxim Interval B	ate
4	Physician									Onset and	d Deeth
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	0.	CVI	4.				1w	cele.
		<u></u>	resulting in death)		Due to (or es a	consequence of):					
	bed nsit	Examiner		<b>b</b> .						1	
. 6	the death certificate be executed y the ettending physician and ached for use as the buriel-transit	хаг	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a	consequence of).					
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S	or Attending after death. Director: After	fica	3 ☐ Suicida 6 ☐ Could	I not be	lury - At home fa	rm, street, factory, office		28f Location /	Street and Number	or Rural Bouta No	mher
Division	5455	Certification:	4 ☐ Homicide deten	mined 200. Flace of In	c. (Specify)	mi, street, ractory, omce		City or To	vn, Stete)	or rural riodis Nu	moor,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai C	Torrock orny 2 Medica	ng Physician: To the best I Examinar: On the basis o	f exemination and	, death occurred at the	time, date and place	e, end due to the urred at the time.	cause(s) and menr dete and place, an	ner as stated.	)(s)
	the mple	-	one) 29b. Signature and title of cartifi	and manner st	atad.		nse number				
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	Sta Registr	16	31. Deta filed (Month, Day, Yee, DEC 2 \$	1998	2612	D	11				



			State of	Marylan		artment of tificate of	Health and M Death		eg. No.	411	13			
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/Medical	4e Facility Neme (#			harl			4b. City, Town, or Lo	Decembe			1:45 P			
Examiner				001)										
uneral	5. Social Sacurity No		Sex 7	. Age (In yrs.	last birthday)	If Under 1 Yaa	Cumberlan	8. Data of Birth (Month, Day	ALLE	9. Birthplace ( Country)	State or Foreig			
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To	THOMAS	HEAPS					LULA B	ARNES						
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r,	resulting in death)		a	Due to (o	r es e consec	quence of):					WEEKS			
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by Physician/Medica	rasulting in death) L			Dua to (or	r es e consaq	uenca of):								
M/Vie		_	d							1				
Sici	Part II. Other signifi	cant conditions	contributing to dea	th but not rasi	ulting in the u	ndarlying causa g	jivan in Part I.	23b. Did to	obacco use co	ntribute to the	ause of death			
eted by Physicia								1 D Y	'es 2□ No	3 Probably	4 Unknow			
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Completed								24a. Was a perfor	mad?	available	on of cause			
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	DC Man and wife	and to mention t						107	es 21 No	1 Yes	2 No			
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B	1 Tyes 2 X		28a. Deta of		28b. Tima of			28d. Dascribe h						
To Be	1 ☐ Yes 2D			Day rear)	Injury		Yes 2 □ No							
To Be	27. Manner of Death 1 2 Natural 2 Accident	5 Panding invastigatio	Suicide 6 Could not be determined  4 Homicide determined  28a. Place of Injury - At homa, farm, street, factory, office City or Town. S								ta Number,			
To Be	27. Manner of Death 1 2 Natural 2 Accident	invastigetio	28a. Place C	4 Homicida determined determined building, atc. (Specify)										
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edical Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida  29a. Certifier (Check only one)  29b. Signature and one 30. Name and address	invastigetio 6 Could not be determined  1 Certifying Pr 2 Medical Examinative of certifier	nysician: To the banner: On the bas and manner completed causa	est of my kno is of examinat ir stated.	tion and/or in	29c. Licer D3 Print)	opinion, death occurrense number	ed at the time, d	late and place,	and due to the o	Year)			
ر Medical Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida  29a. Certifier (Check only one)  29b. Signature and	invastigetio 6 Could not be determined  1 Certifying Pr 2 Medical Examinative of cartifier ass of person who oonal, 9	nysician: To the brainer: On the bas and manner completed causa	est of my kno is of examinat ir stated.	n 23a) (Type, y, LaV	29c. Licer D3 Print)	opinion, death occurrence	ed at the time, d	late and place,	and due to the o	Year)			



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Isabelle REEN **DECEMBER 18,1998** 1:45 P.M. 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SACRED HEART HOSPITAL CUMBERLAND er If Under 24 Hrs. ALLEGANY If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 20 F Months Deys Hours Min. Yrs 220-16-5916 MARYLAND AUGUST 6 1914 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND 1 Ty Yes 2 □ No ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 500 KINGSLEY PLACE 21502 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify Specify: BLACK 3 → Widowed 4 Divorced Yeer or Detes 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 9 HOME MAKER HOME MAKER 17. Father'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JACOB TAYLOR EDITH TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) FAYE COLE DAUGHTER 69 GREENE STREET CUMBERLAND MARYLAND 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND MARYLAND WOOD LAWN CEMETERY DEC 21 1998 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MERRITT-ADAMS FUNERAL MARYLAND MARYLAND Approximate Interval Between Onset and Deeth evil 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not shock, or heert teilure. List only one cause on each line. Immediete Causa (Final disease or condition resulting in death) me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as e consequence ot) Due to 10 Due equence of) es e cor Part II. Other algnificant,conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy partormed? use 2 No 1 ☐ Yes 2 ☐ No cou da 28. Place of Deeth (Check only one)

**Physician** /Medical Examiner

Physician: The law requires that the death certificate be executed

this

After !

the

filled in by

completely

within 24 hours after death. To the Funeral Director: A

or Attending

Hospital

\$

Box 68760,

P.O.

Division of Vital Records.

Department of Important: If any injury or

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

10a. Stete

**Funeral** 

Director

ahow

t than "natural", or items 23s or 28s-f ahor the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after of health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or health yor other thaumate avant, the Medical Empire ury or other thaumate avant, the Medical Empire.

Baltimore, Maryland 21215-0020

the Manyland

death with

Be Completed by Physician/Medical Examiner the for use as signed by the a certificate Medical Certification: To funerai

25. Was case referred to medical examiner?

1 Yes 2 No 27. Menner of Death

1 Neturel
2 Accident 5 Pending investigation 3 ☐ Suicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

8 Could not be determined 4 I Homicide

Hospitel; 1 Appatient

2 ER/Outpatient . Date of Injury (Month, Dey Year)

28b. Time of

1 Yea 2 No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

3 DOA

28c. Injury at Work?

29c. License number

D 13601

Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

**DECEMBER 18,1998** 

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

NO 30. Name and address of parson who completed ause of death (Item 23a) (Type, Print)

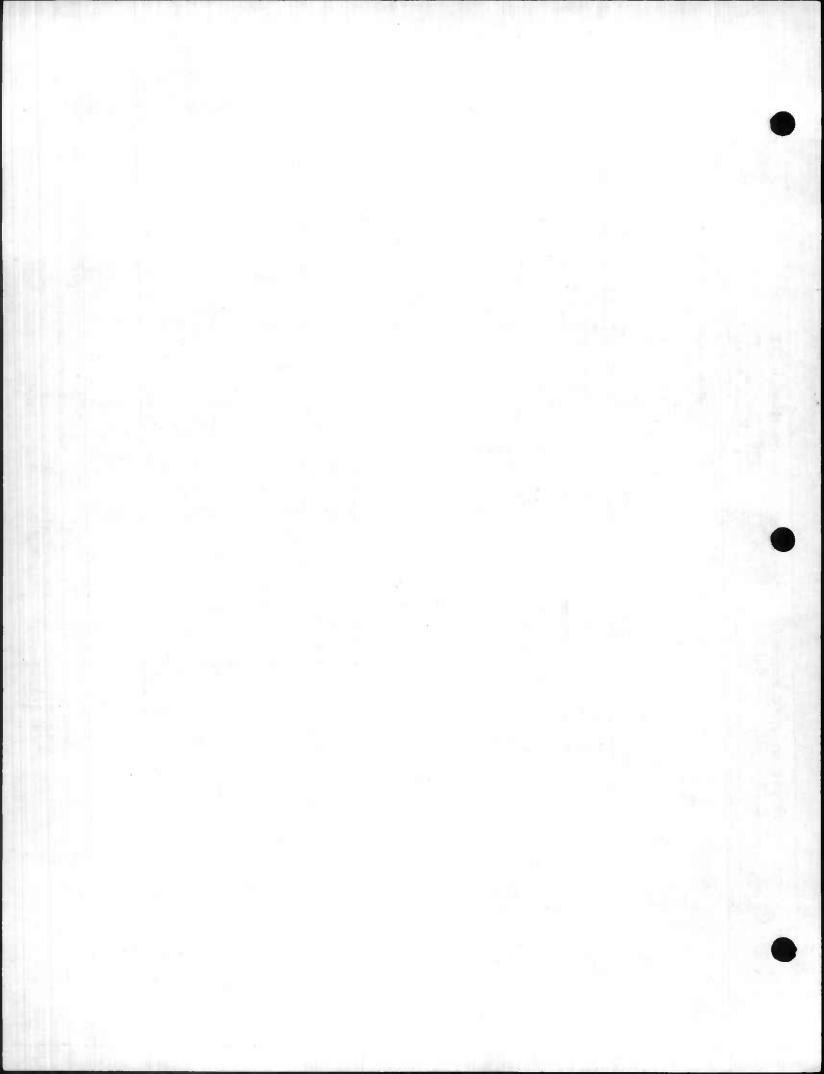
925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 21502 FELIPA V.R.

State Registrar

my

31. Date tiled (Month, Dey, Year) DEC 2 1

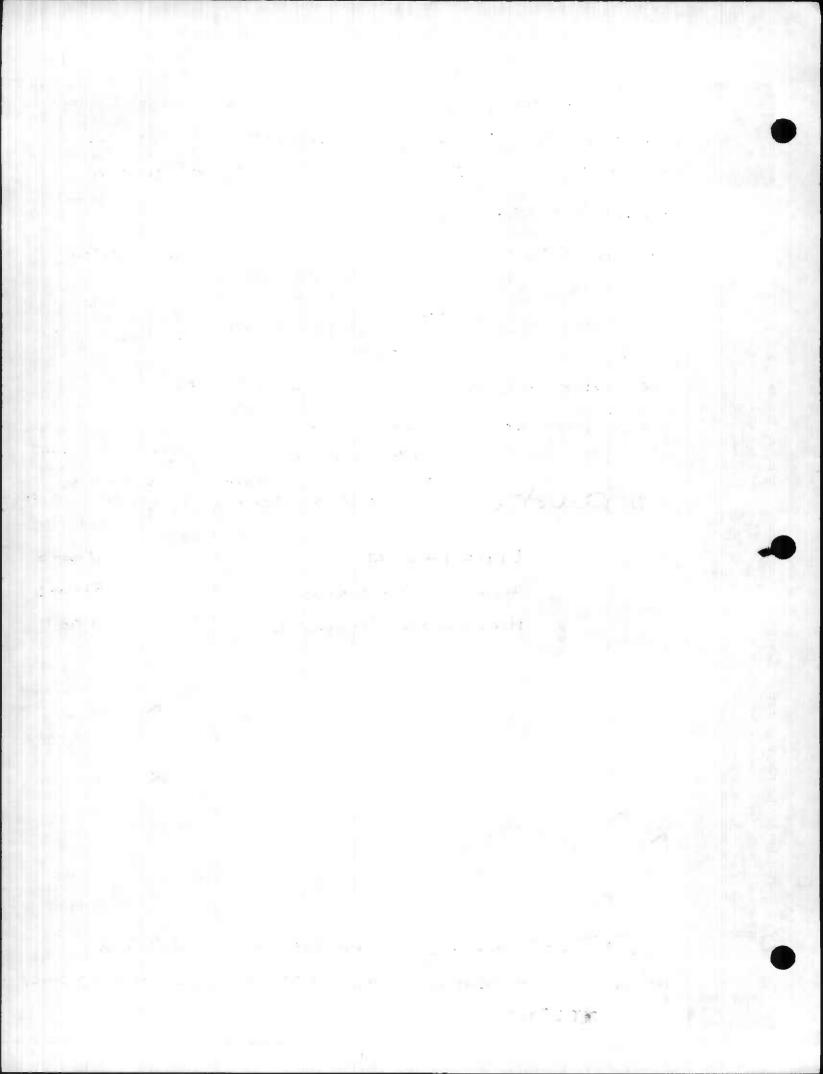
32. Registrer's Signeture



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Dec 15 Physician 1998 George Thomas Groom, Sr. 0950 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 8. Data of Birth (Month, Day, Aug 20 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1943 1 M 2 □ F Months Days Hours Min. 220 42 0230 55 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at MarylandAnne Arundel Edgewater 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 3604 Edgemont Street 21037 United States Funeral death 12. Was Decedent Evar in U.S. Armed Forcas? ※Yas 2□No II Yas, Giva Yaar or Dates Vietman 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural" or the 1 ☐ Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: white P 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Stidham Tire Co. Elemantary/Secondary (0-12) Coilege (1-4or 5+) manager 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) John Carlyle Groom, Jr. Catherine Dean 19a. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 Is n Mary F. Groom- wife same as #10 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata Solomons Maryland 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval Irom Stata 6 Solomons UMCemetery Dec 18 eny injury 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Sarvice Licensee 4405 Broomes Is. Rd. Port Republic MD 2067 Approximata Interval Between Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical LIVER FAILURE 2 DAYS xaminer Due to (or as a consequence of): Examiner 10 DAY S ALCOHOLIC CIRRHOSIS certificate be executed inding physician and use as the burial-trans Sequantially list conditions, if any, laeding to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of) 1 DAY HEPATORENAL 3 MODROM E Physician/Medicai Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of desth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 90 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 3200 1 Ves 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 6 Could not be datarmined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homlcida Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ateted.

2 Section 2 Section 2 Section 2 Section 2 Section 3 Se 29a, Certifier (Check only one) end manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number MD D39037 30. Nama and address of person who completed cause of death (item 23a) (Type, Print) 64 FRANKLID, ANNAPOLIS MO 21401 MITCHELL, AAMC DOUGLAS 5. 31. Date liled (Month, Day, Year) 32. Registraris Signatura State DEC 1 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26, Residence, 12/17/98, drw Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** 1998 ROBERT ERROLL GAINES DECEMBER 14 1404 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 2607 Imperial Court

5. Social Security Number 6. Sex Dunkirk
If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1⊠M 2□ F Deys Hours Yrs. **Director** 578-40-1402 67 9/2/31 Wash., D.C. Usual Residence of Decedent the Marylend 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at ¥Yes 2 No Directo MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2607 Imperial Court Funeral USA 14. Race - American Indien, Black, White, etc. 20754 death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after XOXYes 2 □ No ITYes, Give Year or Dates: WW II 1 Never Married 2 Merried 1 ☐ Yes 2 X No Specity: Specify: by 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wn Department of Heelth and Mental Physien. Important: if item 27 ie marked other tha any injury or other traumatic event, the pance. retail sales business owner 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Robert Erroll Gaines, Sr. Eleanore B. Miller 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2607 Imperial Court, Dunkirk, MD 20754

20b. Plece of Disposition (Name of cametery, cremetory or other pieca)

20c. Location - City or Town, Stete Sharon Gaines/ wife 20e. Method of Disposition t \text{\text{Buriel}} 2 \text{\text{Cremetton}} 3 \text{\text{Removel from State}} 4 \text{\text{Donetion}} 5 \text{\text{Other}} (Specify) So. Memorial Gardens 12/18/98 Dunkirk, MD 21. Signeture of Funerel Service Licanses 22. Name and Address of Fecility P.O. Box 121, Dunkirk, MD 20754
Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Raymond Funeral Home, P.A. Approximete Intervai Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) RESPIRATORY FAILURE Examiner Physician/Medical Examiner MONTHS PULMONARY FIBROSIS requires that the death certificate be executed attending physician and for use as the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of) thet initieted events resulting in death) Last Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peen The law certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No 2 within 24 hours after death.

To the Funeral Director: After this completely lilled in by the Iuneral di 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pieca of injury - At home, ferm, street, factory, office building, etc. (Specity) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical (Check only one)

20

2

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Much MD.

DR. PETER WISNIEWSKI, M.D. PRINCE FREDERICK, MD 20678

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

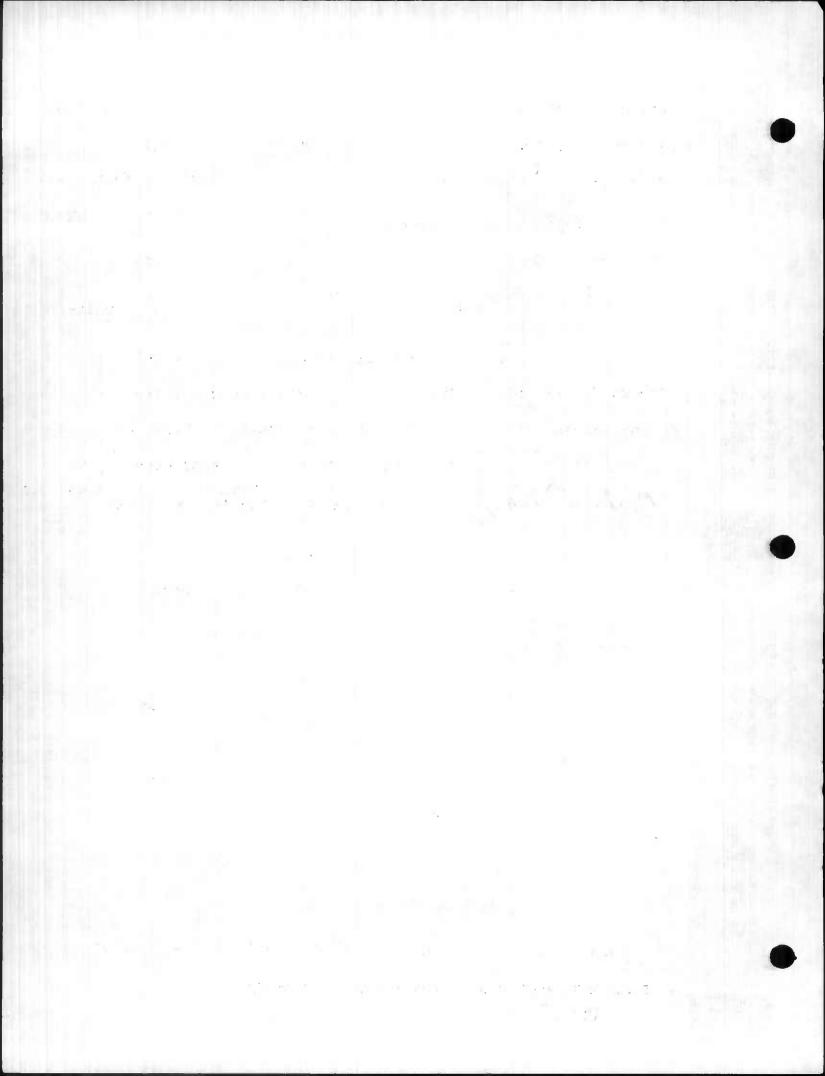
29d. Date signed (Month, Day, Year)

98

31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

29b. Signature and title of certifier

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month CLARENCE GUEST DEC 22 1998 4:13 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY H Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Y Sept. 19 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 9 1922 Enid, Okla. 1 € M 2 □ F 76 Yrs. 446-14-3562 Sept Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Fort Washington Maryland Prince George 1 No 2 No 10e. Street end Number 10f. Zlp Code 10g Citizen of What Country? 20744 4200 Flam Street IISA 12. Wes Decedent Ever In U,S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give 1966 - Yeer or Dates: 1976 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Merried 2 Married Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 1970 15. Decedent's Education 16a. Decedent's Usuei Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Associate Professor D.C. Government 4+ 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Alta Zephyr Pettie Clarence Arnold Guest, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meliing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4200 Flam St., Ft. Washington, Md. 20744 Shirley A. Guest (Wife) 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 12/30/98 Arlington, Va. Arlington National 4 Donation 5 Other (Specify) 21. Signaluze of Con-22. Neme end Address of Fecility Jordan Funeral Service, Inc 4001 Benning Rd., N.E. (Wash., D.C. 20019) 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or haer failure. List only one cause on each line. Onset and Death Immediate Cause (Finel disease or condition resulting in death) INTRACEREBRAL HEMORRHAGE Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed?

**Physician** /Medical Examiner

Bud

physician

need

certificate

this

Affer

Hospital or Attending 24 hours after deeth.

director.

requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Àq

Completed

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Marylend

72 hours efter

Hygiene.

permit. Peges 1 and 2 should be filed wit Depertment of Heelth and Mantal Hygiene Important: If Item 27 is marked other tha eny injury or other traumatic event, that,

Baltimore, Maryland 21215-0020

Physician/Medical Examiner -transit the 80 attending p signed by the a à Completed page 2 Be 10 To the Hospital or Attendition 24 hours after deeth.

To the Funeral Director: A completely filled in by the for

Certification:

Medicai

3 ☐ Suicide

29e. Certifier

4 Homicida

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical 26. Plece of Deeth (Check only one)

1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 1 Naturel 2 Accident 5 Pending Investigation Injury 6 Could not be determined

28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 ☐ Yes 2 No

1XX Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medicat Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. 29b. Signeture and title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number

Jun

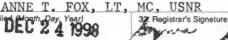
D-0054195 (MD)

1 TYes 2 No

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar





**DHMH 16 Ray 6/95** 

in the same of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death **Physician** 3. Time of Death Month LUCIOUS CHARLES GOODIN /Medical December 1998 2200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10718 Brookwood Avenue Upper Marlboro Prince George's **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 1⊠ M 2 ☐ F Days 258-50-9473 58 Yrs. Hours Min Usual Residence of Decedent 1940 Georgia filed within 72 hours after death with the Manyland 10b. County 10c. City, Town or Location ris 23s or 28s-f show 10d. Inside City Limits MD Prince George's 1⊠ Yes 2 No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? terms 23a 10718 Brookwood Avenue Funeral 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1☐ Yes 2☑ No Baltimore, Maryland 21215-0020 netural, or If Yes, Give 1 YES 2 NO À 3 Widowed 4 Divorced Specify: Year or Dates Completed Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired.) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry 9 Welder 17. Father's Name (First, Middle, Last) 1 and 2 should be fi Health and Mental F 18. Mother's Name (First, Middle, Maiden Surname) 8 JAMES 0 GOODIN **EMMA** KELLY of Health and N Rem 27 is man other traumal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Goodin - Wife 4452 B Street, SE #301, Washington DC 20019 20a. Method of Disposition permit. Pages 1 Department of H Important: If the any Injury or ot gage. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Dec 18 4 Donetion 5 Other (Specify) Chesapeake Crematory Beltsville, MD 1998 Signature of Foheral Service Licenset 22. Name and Address of Facility Taylor's Funeral Home 1722 North Capitol Street, Part 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Physician Approximate Interval Between Onset end Death /Medical Immediate Cause (Final Examiner una Cancer diseases or condition resulting in death) Due to (or es a consequence of): Examiner physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760. certificate be Physician/Medical Due to (or as a consequence of). for a signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 2 should Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to hes completion of cause of death? certificate of Vital 1 Yes 2 No 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Sid. 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 28a. Date of Injury (Month, Day, Year) Division 27. Manner of Death Athending 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Al extrapolately illed in by the fi 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) State

30 Nat

29b. Signature and title

Zafar Ansari, M.D. 8926 Woodyard Road, Suite 101, Clinton, 32. Registrar's Signature Me Doon B. fores

MD

ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

3219

D005

29d. Date signed

18

(Month, Day, Year)

98

DEC 2 1 1998

386 1 ; 330

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 10 0/10 Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month CATHERINE OLIVIA GAMBLE 17, 1998 December 7:03 A.M. /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 9. Birthpleca (State or Foreign Country)
Washington, D. C. 7. Age (In yrs. last birthday) **Funeral** 1 M 20XF 74 Yrs Director 579-26-3255 Usuel Residence of Decedent 10a Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumetic event, the Medical Examiner must be notified at Yas 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Items 23a Oswego Avenue 20720 Funeral death United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Nevar Merried 2 Merried Baltimore, Maryland 21215-0020 6 1 Yas 2 No Specify: BLACK ρ 3 🕅 Widowed 4 🗆 Divorced 'natural', Completed 16e. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) House wife 12 Privat Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is merked other eny lightly or other traumetic event, soice. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be GEORGE SHACKLEFORD LOUISE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY GAMBLE / Daughter 49 Oswego Avenue, Silver Spring, Md. 20720 20b. Plece of Disposition (Name of cematery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Ststa 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY DEC 26,98 SILVER SPRING, MD. 21. Signature of Funeral Service Licens 22. Neme end Addrass of Facility ALEXANDER S. POPE FUNERAL HOMES M859 2617 Pennsylvania Avenue, SE DC 20020 23a. Pert1. Entar the disease, or complications that ceused tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one vause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediata Ceusa (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown signed by 1 Yee 2 No Division of Vital Records, þ 24b. Were eutopsy findings svailable prior to completion of cause of death? Completed 24e. Wes an sutopsy performed? 2000 certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Pleca of Deeth (Check only one) Hospitel: 1 Yes 20 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Menner of Deeth Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After 1 Maturel 5 Pending investigation death. 2 No ours after death. eral Director: A filled in by the fo 1 Yes 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide To the Hospital o within 24 hours af Medical 11 Certifying Phyelcian: To the best of my knowledge, daeth occurred et the time, dete end place, and due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a, Certifier 29b. Signature and title of certifie 29c. Licensa number 29d. Data signed (Month, Day, Year)

State Registrar 31. Dete filed (Month, Day, Year)
DEC 2 1 1998

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32. Registrar's Signeture

of death (Item 23e) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene

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	Examine	VANTAGE HOU	SE						COLUM	RTΔ		LIC	WARD	
	Funeral	5. Social Sacurity Number	6. 5		Aga (In yrs. la	st birthday)	If Undar 1		If Undar 24		Data of Birth Month, Day,	Year)		aca (Stata or Foreig
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	Mar To	MARYLAND H	IOWAR	D				CO	LUMBIA					1⊠ Yas 2□No
	or 28s-4 s or 28s-4 s be notified Director	10e. Street and Number					10f. Zip C	oda			10	g. Citizen of	What Coun	try?
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	r flems 23 diner must	11. Marital Status	101	12. Was Decedar	nt Evar in U,S	. 13.	Was Decede			? (Specify	Specify Yas or No- 14. Race			an Indian,
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Maryland		CLARENCE ED					RUTH	N. BA	KER					
ary	S DE E	19a. Informant's Name/Rala				19b. Maili	ng Addrass (	Street	and Number			City or Town	, Stata, Zip	Code)
	D 5 1 5	JAMES G. THOMPSON/COUSIN P.O. BOX 150, ROHRERSVILLE, MARYLAND 23										217	779	
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Baltimore,	in property	21. Signatu of Fineral Ser	-		1 100	1	2. Nama and							
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	eath certificate be executed attending physician and for use as the burial-transit clary/Medical Examiner	Sequantially list conditions, if any, leading to immediate	ſ	b	Due to (or	as a conse	quence of):							
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0.	= 50	Colon	CA								1 🗆 Ye	e 2□ No	3 Prot	pebly 4 Ounknow
Records,	been should										24a. Was ar perform		COL	ere autopsy findings allable prior to mpletion of cause death?
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Vital	ysician: The is certificate director, page Co	25. Was case referred to me examiner?	dical						26. Place o	f Death (Cr	neck only one	9)		
5	Y Sp	1 Yes 2 No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									1)	
sion of	ding h. After fune		anding vastigation	28a. Data of In (Month, L	jury Day Year)	28b. Tima o tnjury	f 28	c. Injui Wor	yat rk? Yes 2 □ No		Describe ho	w injury occu	rred	
S	dead tor: the		ould not b	e 29a Place of I	Iniuny - At hon	na farm et	reat factory	office		28f	Location /Str	reet and Num	her or Bure	l Routa Number

To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completally filled in by the f

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) end manner stated.

29e. Cartifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licensa number

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

32. Registrar's Signatura

D50338 Dec. 28, 1998

Poblete

6 Could not be determined

MD, 11055 Little Patuxent Parkway Columbia MD 21044

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

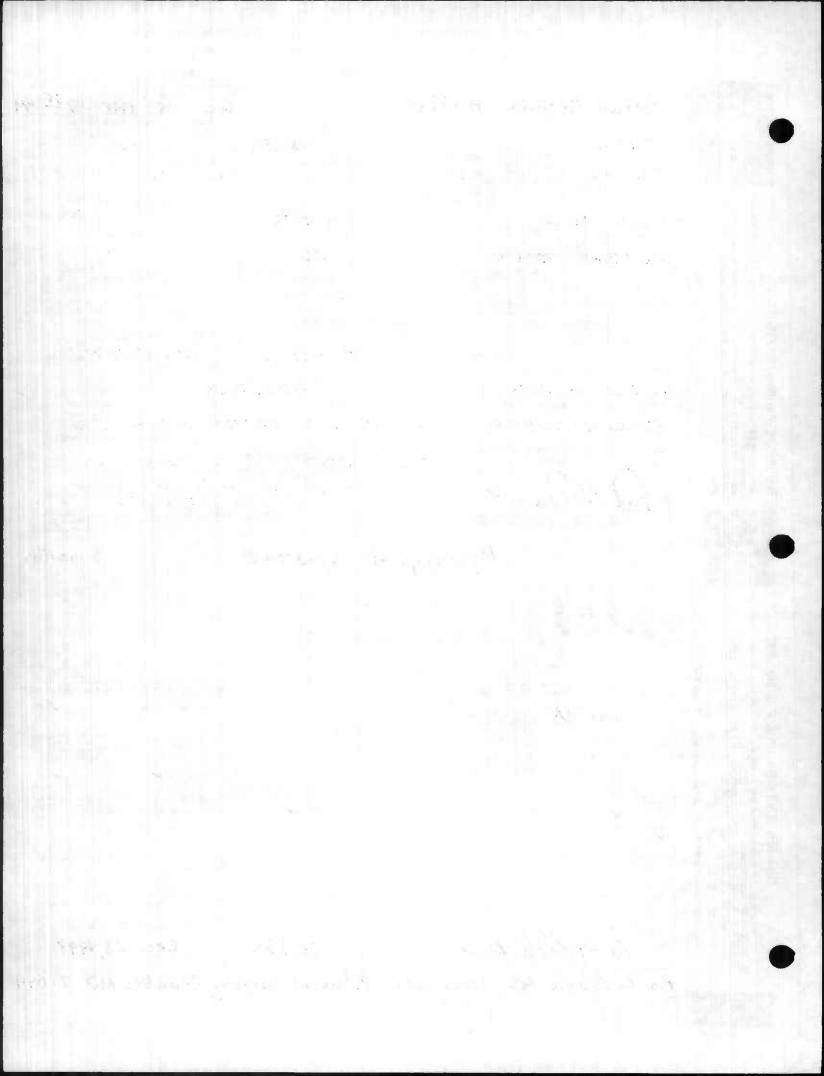
State Registrar

Medical Certifica

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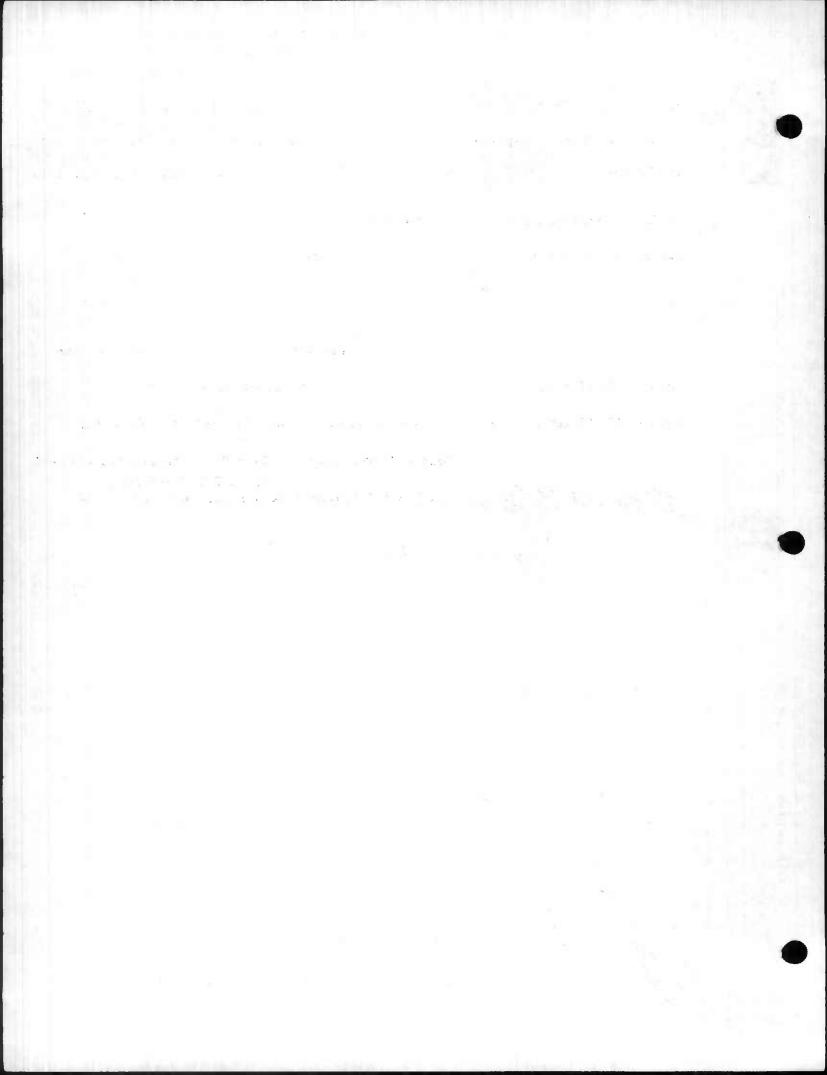
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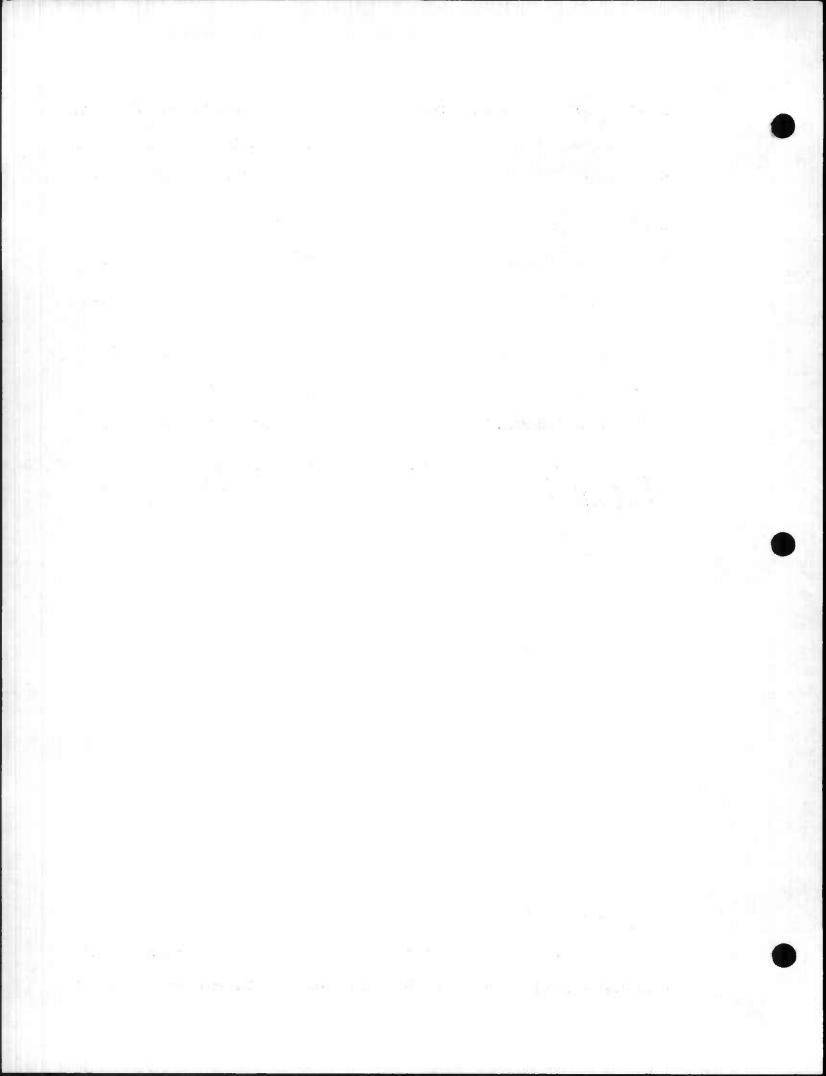
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n Z/		Anna E. Willingh	am - niece				erry St.	Hagers	town, M	ld. 2	1740
- 2	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Damousl from Class	20b. Plece ceme	of Disposition (Natery, crematory of	lame of r other plac	ca)	Dete	20c. Location	- City or T	own, Stata
ITY OF		1 ➡ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			e Hill C			-29-98	Hagers	stown	,Marylar
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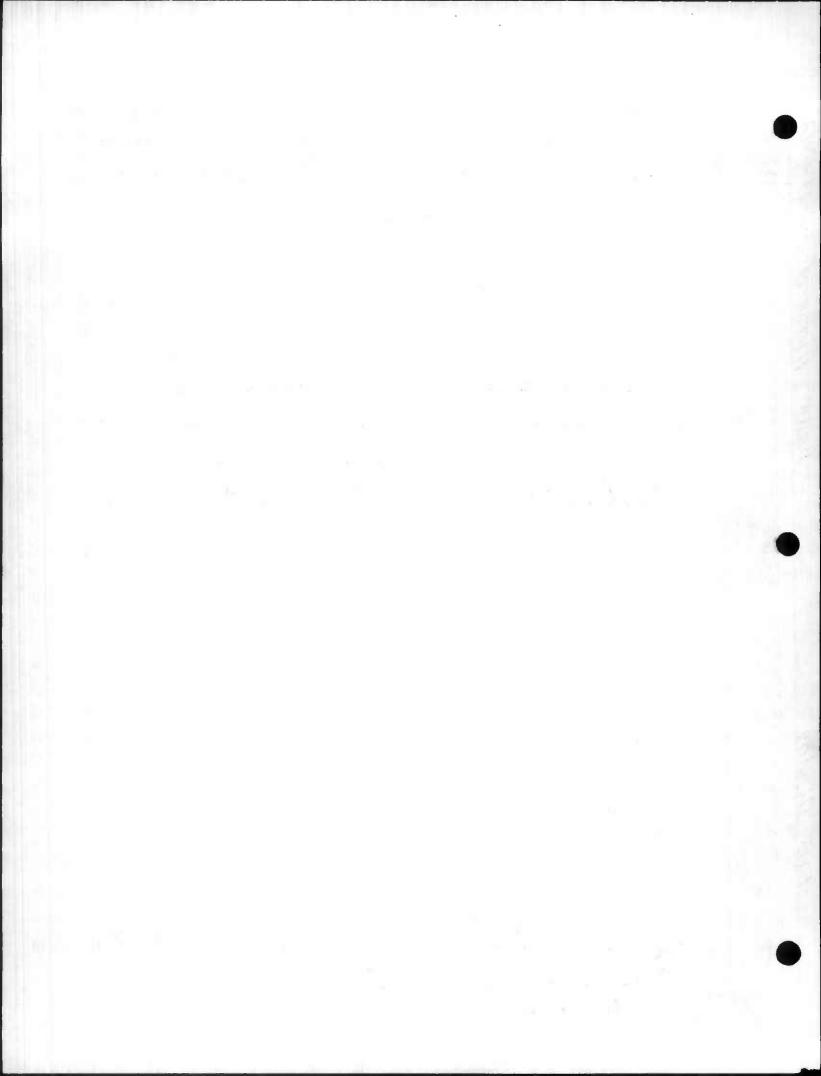
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month MARGARET COVINGTON HAWK 0215 December 24,1998 /Medical 4e. Facility Neme (If not institution, give street end number) 4b, City, Town, or Location of Deeth 4c. County of Deeth Examiner Atlantic General Hospital Berlin Worcester if Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foraign Country) **Funeral** Days Hours 1 M 20 F Director Yrs. 215-14-3012 80 November 3,1918 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at Maryland Somerset Director Pocomoke 1 ☐ Yes 2 No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 6 8894 Courthouse Hill Rd 238 21851 USA Herma ; 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American indian, Black, White, etc. 1 ☐ Never Married 2 Married "natural", or 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. Homemaker 12 Domestic traumatic event, 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Pages 1 and 2 should be nent of Health end Mental William Wallace Covington P Mary Hearn Merrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) .00 permit. Pages 1 and 2 Department of Health e Important: If Itam 27 is any injury or other tra Donald N. Hawk/Husband 8894 Courthouse Hill Rd., Pocomoke, MD 21851 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/98 Pocomoke, MD Salem U.M. Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Holloway-Melson Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pocomoke City, MD 21851 Approximate interval Between Onset and Death **Physician** /Medical immediete Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificeta be executed buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pul Due to (or se a consequence of): P.O. Box 68760, Physician/Medical the Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco uss contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Š page 2 should 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical 26. Place of Deeth (Check only ona) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To this 27. Manner of Deeth . Date of Injury (Month, Day Year) 28b. Time of After t 28c. injury at Work? 28d. Describe how Injury occurred or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by determined 4 T Homleide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner et aled. Medical (Check only \$ 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Yaer) 29c. License number e and address of person who completed ceuse of death (Item 23a) (Type, Print Drive calthwar

32. Registrar's Signature

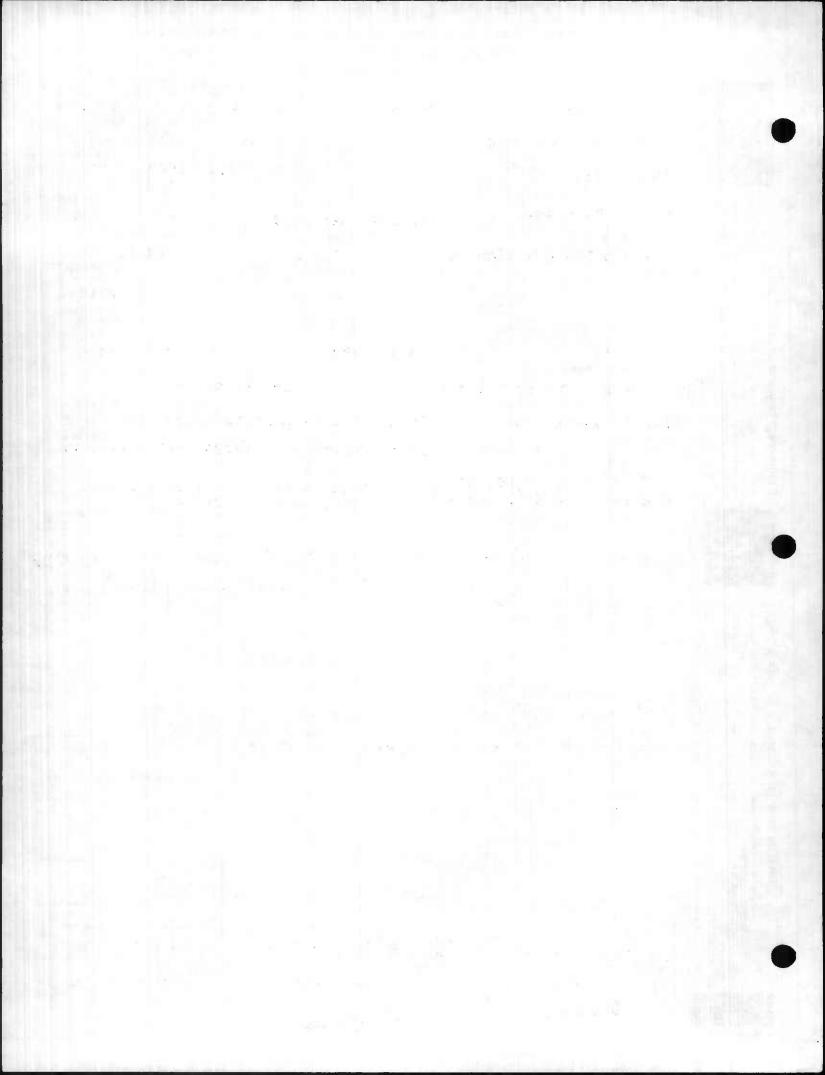
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Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Death

Certificate of Death

2. Dete of Death

3. Time of Death

5		Physic /Med Exami	ical
	   	Funera Director	
5-0020	2 hours after death with the Maryland	latural, or items 23a or 28a-f show ical Examinet past be notified at	ted by Funeral Director

Month Dey MARY LOUISE HOUSER 23, DEC. 1998 7:50 PM 4e. Fecility Neme (If not institution, give street and number) CONVALESCENT 4b. City, Town, or Location of Deeth 4c. County of Deeth WESTMINSTER NURSING AND CENTER WESTMINSTER CARROLL 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months Days Hours Min. | 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 M 200 448-36-7832 MAR.16,1900 Indiana Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits MD Carroll Westminster 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 445 Pleasanton Rd. #33 21157 United States 12. Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien 1 Never Merried 2 Merried 1 Yes 2 No
If Yes, Give
Yeer or Detes: White 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Specify: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Comple Elementery/Secondary (0-12) College (1-4or 5+) 1 1 Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be David Gordon Cummins Lillie Koch 2 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 7 19a. Informant's Name/Relationship (Type, Print) Ellouise Barnes/daughter 445 Pleasanton Rd. #33, Westminster MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. 12/28/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture/of Funeral Service Licensee 22. Name end Address of Fecility 91 Willis Street

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mertial Hygiene. Important: If Item 27 Is marked other than \*, any Injury or other traumatic event, the Mat 2000s.

Baltimore, Maryland 2121

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury training in death) Last

Immediate Cause (Finel disease or condition resulting in deeth)

Due to (or as a consequence of):

23a. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory errest, a formal failure. List only one cause on each line.

15 yr

Approximate Interval Between Onset and Death

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Certification:

Medicai

29e. Certifier

(Check only

Pert II. Other eignificant conditions of	ontributing to deeth but not re-	sulting in the und	lertyin	gcaus	e given In	Pert I.		23b. Did tobacco	ousa co 2 No	ntribute to the d	ause of death?
								24e. Wes en euto pertormed?	opsy	24b. Ware au evelleble completi of deeth	prior to on of cause
								1□Yes 2	No	1 🗆 Yas	2 No
25. Wes case referred to medical examiner?					28.	Plece of D	eeth (	Check only one)			
1 ☐ Yes 2 💢 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetlent	3□	DOA	Other: 4	Nursing	Home	5 Residence	8 Oth	er (Specify)	
27. Menner of Deeth  1   Naturel 5   Pending  2   Accident  Investigation		28b. Time of injury	М	28c.	injury at Work? 1 ☐ Yes	2 🗆 No	28	d. Describe how Inju	iry occur	red	
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	ome, ferm, stree fy)	t, fect	ory, of	fice		28	f. Location (Street et City or Town, Stete	nd Numb e)	per or Rural Rout	e Number,

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29b. Signeture end title of certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner es stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated.

It it is of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

Myers Funeral Home Westminster, MD 21157

30. Name and express of person who completed cause of death (Item 23a) (Type, Print)

D25443

John Middeton 7

State Registrar 31. Dete filed (Month, Dey, Year)

DEC 2 8 1998

DEC 2 8 1998

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 4 1 26 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dey Month Physician ALICE HOHMES DECEMBER 1798 2:00 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTER RANDALLSTOWN J ATIGIZOH NORTHWEST BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 25 F 579-36-9189 93 Yrs. Sept 12 1905 Director Indiana Usuai Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inaida City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Carroll Md Sykesville 1 Yes 2 No Director 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 2306 Lake Circle Drive 21784 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No II Yes, Give Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Stetus Black, Whita, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "naturel", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white à 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) (Specify only highast grade complated) College (1-4or 5+) +2 Elementery/Secondary (0-12) U.S. Government executive secretary treumstic event. 18. Mother's Neme (First, Middle, Malden Sumema) 17. Father's Neme (First, Middle, Last) Harry Lee Burns Nettie L. Conrad 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) permit. Peges 1 and 2 st Department of Health and Important: If Item 27 Is m any Injury or other treum pncs. Shar Hohmes (daughter-in-law) 2306 Lake Circle Dr., Sykesville, MD 21784 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Dauriel 2 Cremetion 3 Removel from State Cedar Hill Cemetery 12/21/98 Suitland, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel Page Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Pert1. Enter tha diseesa, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert lailure. List only one cause on each line. Approximate Intervai Between Onaet and Deeth **Physician** /Medical Immediate Ceuse (Finei disaesa or condition resulting in deeth) · CONGESTIVE CARDIOTIYOPATH EARS Examiner Due to (or es e consequence of): Examiner physician and s the buriel-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or es e consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical thet initieted events resulting in death) Lest Due to (or es a consequence of): USB Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? the 6 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown DEMENTIA signed t by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed RENAL INSUFFICIENC has page 2 1 Yes 250 No 1 ☐ Yes 2 ☐ No 9 certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending Patter death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 Suicide 28l. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) end menner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner ateted. 29e. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. Licansa number 29d. Date aigned (Month, Day, Year) DECEMBER 17,98 D 43462 . S. R A O . M.D 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) 1 C. S. R. A. C. M. O. HOSPITAL CENTER RANDALLSTOWN, MID NORTHWEST

DHMH 16 Rev 6/95

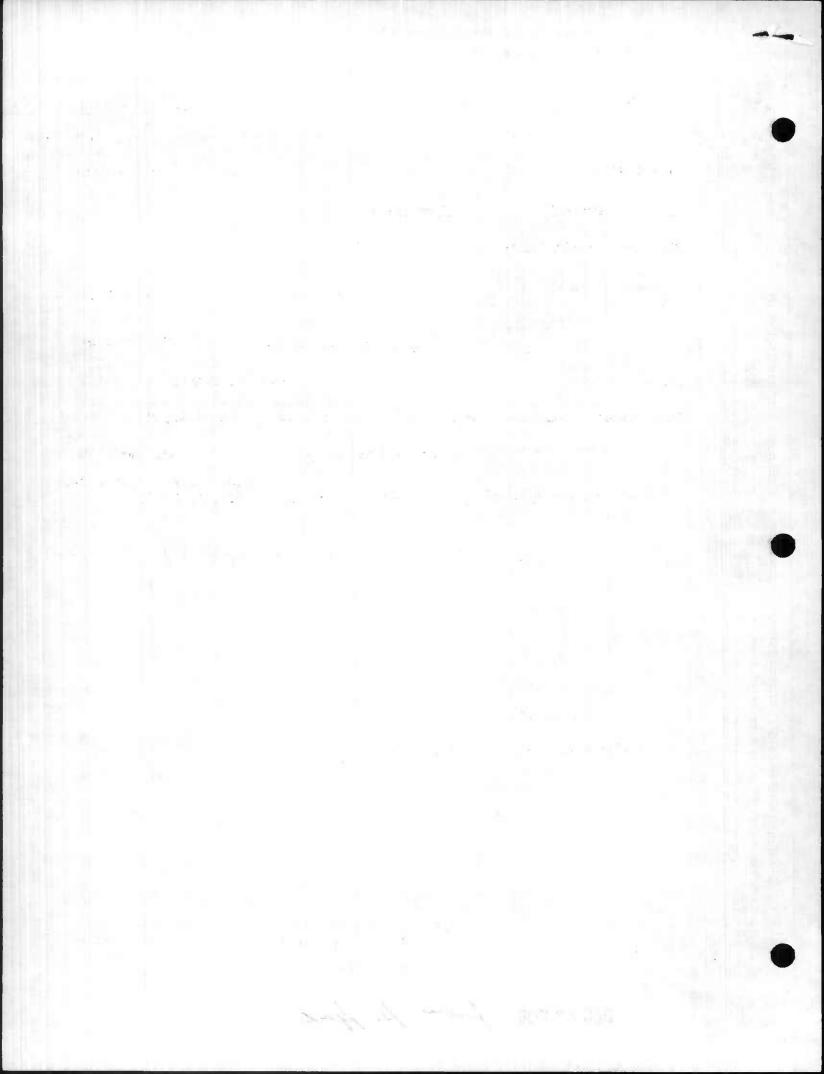
State

Registrar

31. Dete filed (Month, Day, Year)

DEC 2 2 1998

32. Ragistrar's Signeture



**Funeral** 

Director

28a-f show

238

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experimen mant be notified at "natural", or items 1 ☐ Yes 2 No Specify. by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) is marked other than Elementery/Secondary (0-12) Collega (1-4or 5+) Road Maintenance 12 17. Father'e Name (First, Middla, Last) Edward Henry Hinman Viola Otis Bair 19a. Informant's Name/Ralationship (Type, Print) Department of Health ar important: If item 27 is any injury or other traugones. Patrick D. Hinman/Son 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20a. Method of Disposition Data 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 22. Name end Addrass of Facility JOHN P. KNISLEY M01164 Physician Immediata Causa (Final disaasa or condition resulting in daath) /Medical ARDIAC ARRHYTHMIA Examiner Physician/Medical Examiner ATHEROSCLEROTIC lician and bunal-transit HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial 68760, Due to (or as a consequence of) 98 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Be Completed by Division of Vital al or Attending Physician: The safter death.

I Director: After this certificate of in by the funeral director, pa 25. Wes casa rafarred to medical axaminar? Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Menner of Death 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding invastigation Natural 2 Accident 1 Yas 2 No 6 Could not be datarmined 3 Suicide 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Specify) in 24 hour.
The Funeral Direction by 4 Homicide 29a. Certifiar Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signatura and title of certifiar 29c. Licansa number -chad D 50653 30. Nama end addrass of person who completed causa of death (Itam 23a) (Type, Print)
GYAN CHAND SURANA 5851 - DEALE CHURCHTON RD. DEALE M.D. 31. Data filed (Month, Day, Year)
DEC 3 1 1998 32 Registrar's Signatura State

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death **Physician** DECEMBER 29 1998 HINMAN 11:45 PM DALE EVERETT /Medical 4e. Fecility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans' Home St. Mary's Charlotte Hall H Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month Day, Year) June 15, 1915 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplaca (Stata or Foreign 1 M 2 □ F 522-03-3657 Indiana Yrs 83 Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits St. Mary's 1 ☐ Yes 2 No Maryland Charlotte Hall Director 10e, Straat and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 U.S.A. Funeral 12. Wes Decedent Evar in U,S.
Armed Forcas?

1 IX Yes 2 □ No 1944 –
If Yas, Giva
Yaar or Datas: 1946 14. Rece - Amarican Indian, Biack, White, etc. Was Decedant of Hispenic Origin? (Spacify Yas or No-if Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 1 Nevar Married 2 Married White 16b. Kind of Business/Industry State of Colorado 18. Mothar's Nama (First, Middla, Maiden Surname) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2227 Newburgh Court, Waldorf, Maryland 20c. Location - City or Town, Stete Jan.6,1999 Salida, Colorado The Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween 5 minures MURE THAN IYEAR 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings aveileble prior to complation of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 2 No 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

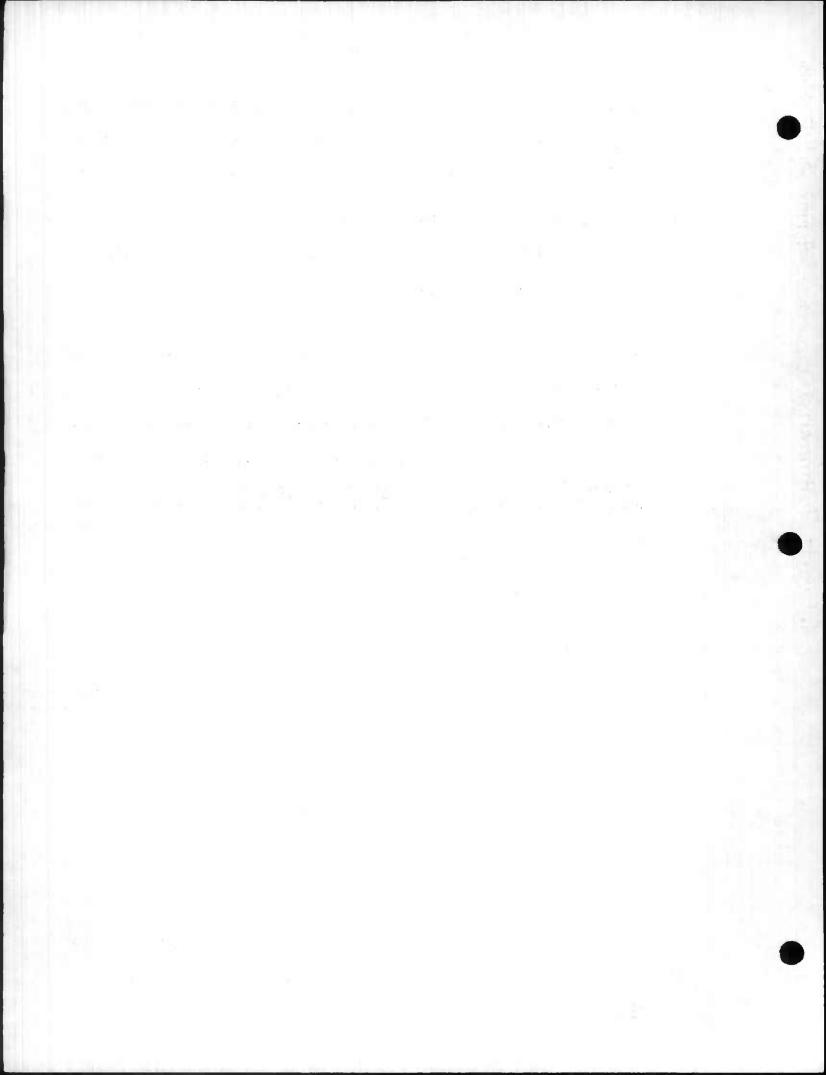
Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8

1 Cartifying Physician: To the bast of my knowledge, deeth occurred at tha tima, date and piece, end dua to tha causa(s) and manner as stelad.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end piece, and dua to the cause(s) and manner stated.

29d. Data signed (Month, Dey, Year)

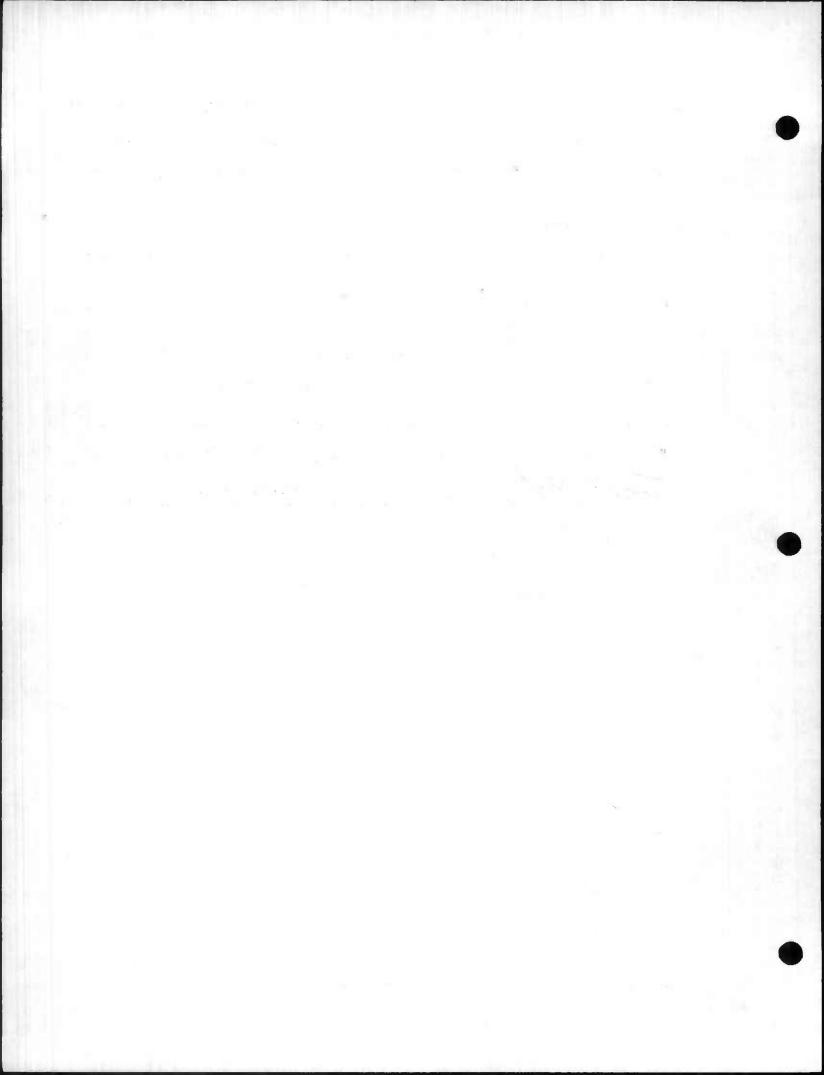
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			State of	Maryland		tment of F ificate of		nd Mental Hy	giene 5 8	4 2	8 .	
Dharata		1. Decedent's Name (First, Middle, Li	ist)					2. Dete of De Month	eth	3. Time	of Deeth	
Physic /Medi		Mary Elizabeth Ha	inks					Decembe	er 17, 19	98 1317	7	
Exami		4e. Fecility Neme (If not Institution, gi		n, or Location of Deet	h 4c. County o	of Deeth						
		14728 Patton Way					Scot1a		St. Ma			
Funeral Director		312-16-9907	Sex 1 □ M 2 ■ F	Age (In yrs. la		Months Deys	Hours	Min. 8. Dete of Bir (Month, De February	th ly, Year) 7 13,1918	9. Birthplece (Stete Country) Indiana	or Forei	
and w		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City.	Town or Loca	atlon				10d, Inside (	City Limi	
within 72 hours after death with the Maryland ena. than "natural", or items 23s or 28s-f show he Medical Examinet must be nothed at	ctor	Maryland St. Man				1 2 20 1 20 20 20 1	s 2 1 N					
1 2 2 E	Dire	10e. Street end Number				10f. Zip Code			10g. Citizen of WI	het Country?		
ath v	rai	14728 Patton Way				20687			United			
permit. Fages I and 2 should be filed within 72 hours after death with the Maryfan Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Instructions if the XT is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be not field at additional and injury or other traumatic event, the Medical Examiner must be not field at additional and any injury or other traumatic event, the Medical Examiner must be not field at	by Funeral Director	11. Maritel Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	es? No	If Yes, specify Cuban			in? (Specify Yes or No Puerto Rican, etc.)	14. Race Bleck Specify:	- American Indien, , White, etc.		
72 ho	Completed	15. Decedent's E			16e. Decede	nt's Usuel Occup	's Usuel Occupetion			iness/industry		
an r	npie	(Specify only highest gr Elementery/Secondery (0-12)	College (1-4	or 5+)	life. DO	nd of work done NOT use retired	during most of d)	or working				
Hygier Hygier ont, th	Co	12			Civi	1 Servi			U.S. D			
should be fill and Mental H marked oth umatic even	To Be	17. Fether's Neme (First, Middle, Lass Charles Brookshir						s Neme (First, Middle ie Worthir		)		
and N is me		19a. Informant's Name/Relationship	Type, Print)		19b. Meiling	Address (Street	end Number	or Rural Route Numb	er, City or Town, S	itete, Zip Code	183	
and		Donald Baugh,	So	n				Vista BLv				
S T T T		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Domousi from Ct	COL	netery, creme	tion (Neme of story or other ple	ce)	12-28-98	20c. Location - C	City or Town, Stete		
nent of h	1	4 □ Donation 5 □ Other (Speci		Ar1	ington	Nationa	1 Ceme	tery	Arlingt	on, Virgi	nia	
Departm fmports any inju		21. Edward N. Brin	NO	Jr. M0(	F	Name end Addre	1d Fun	eral Home,	P.A.	m. MD 206	550	
earn continuate be expected attending physician and attending physician and to rise as the prival-transit tor use as the prival-transit.	Physician/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b. Cow c. Thyl	du	ene							
the att	sici	Pert II. Other significant conditions of	ontributing to deat	h but not resuit	ting in the und	erlying cause giv	ven in Pert I.	23b. Did	23b. Did tobacco use contribute to the cause of deat			
igned by the be datached	by Phy							10	Yes 2□No	3 Probably	Unkno	
s been s 2 should	Completed t							24a. Wes	en eutopsy ormed?	24b. Were eutopsy eveileble prior completion of of deeth?	to	
								10	Ves alle	1  Yes ≥	INO	
is certificata director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (Check only	one)			
Aftar this funeral di	ation: To	1 Yes 2 No  27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of I	atient 2□E Injury 2 Day Year)	R/Outpatient 28b. Time of Injury	28c. Injur Wor	4 LI NUIS		dence 6 Other			
2 - 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)			mber,						
within 24 hours at To the Funeral D completely filled I	edicai	29a. Certifier (Check only one)  Check only one)	yalcian: To the be ninar: On the basis end menner	s of exeminatio	ledge, deeth o on end/or inve	ccurred et the tin stigetion, in my o	me, dete end piece, end due to the cause(s) and menner es steted.  pinion, deeth occurred et the time, dete end placa, and dua to the cause(s)				(s)	
Within Comp	Me	29b. Signeture end title of certifier	0			29c. Licens	e number		29d. Dete signed	(Month, Dey, Year)		
		Chic	war			DI	536	9	12/211	98		
OB		30. Neme end address of person who Umed K. Shah, M.I		ot deeth (Item 2			m. Mar	yland 2065				
Sta	te	31. Dete tiled (Month, Day, Year)		Istrer's Signetu		marutow	n, ral	y Lanu 200.	,,,			
Registr	-	DEC 2 1 1998	Seren	B	lan							

DHMH 16 Rav 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \( \) Certificate of Death

Physician	
/Medical	
Examiner	ı

**Funeral** Director Funeral

the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at deeth filed within 72 hours efter Hygiene.

/Medical Examiner

Examiner

Physician/Medical

Completed

Be

2

Certification:

edical

permit. Pages 1 end 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, me Meda page. Physician ettending physician and for use as the bunel-transit The lew requires that the death certificate be executed Box 68760, ed by the e P.O. peen certificate has or Attending Physician: this Affer t n 24 hours after death.

Ne Funerel Director: Af pletely filled in by the fu death. pletely within 2

1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month DOROTHY Barbara HARWOOD DECEMBER 27, 1998 2313 PM 4e Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick
If Under 1 Year If Under 24 Hrs. 8. Dete Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Deys 1 M 2 X F Yrs. 56 483-58-7760 September 29,1942 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e, Stete 1 Yes 20 No Calvert St. Leonard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20685 U.S.A. 1218 Calvert Beach Road 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Bleck, White, etc. 11. Meritei Stetus 1 ☐ Yes 2 🔯 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Register Nurse 2yrs Hospital 18. Mother's Neme (First, Middle, Malden Surneme) 17. Father's Neme (First, Middle, Last) Joseph Raymond Tippett Betty Lucy Morgan 19e, Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1218 Calvert Beach Road, St. Leonard, MD 20685 James G. Harwood, Husband 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ₺ Burlei 2 □ Cremetion 3 □ Removel from State Charles Memorial Gardens 12/31/98 Leonardtown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. 23e. Pert1. Enter the disease, of complice shock, of heert feilure. List only one ordiner P.O.Box 270, Leonardtown, MD 20650 lications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, the ceuse on each line. Approximate interval Between Onset end Deeth Immediate Ceuse (Fine disease or condition resulting in death) 2 WEEKS HEPATIC FAILURE Due to (or es e consequenca of): MORETHAN 2 YEARS IRRHOSIS DF Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequenca of): MORETHAN CRYPTOGENIC 2 YEARS. Due to (or es a consequenca of): 23b. Did tobacco use contributs to the causs of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably Unknown ACUTE RENAL FAILURE à 24b. Were autopsy findings available prior to completion of cause of deeth?

HUPERKALEMIA.

24a. Wes an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No

25. Wes case referred to medicel examiner? 28. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2□ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

eyon chand

Surana

50653

12-28-98

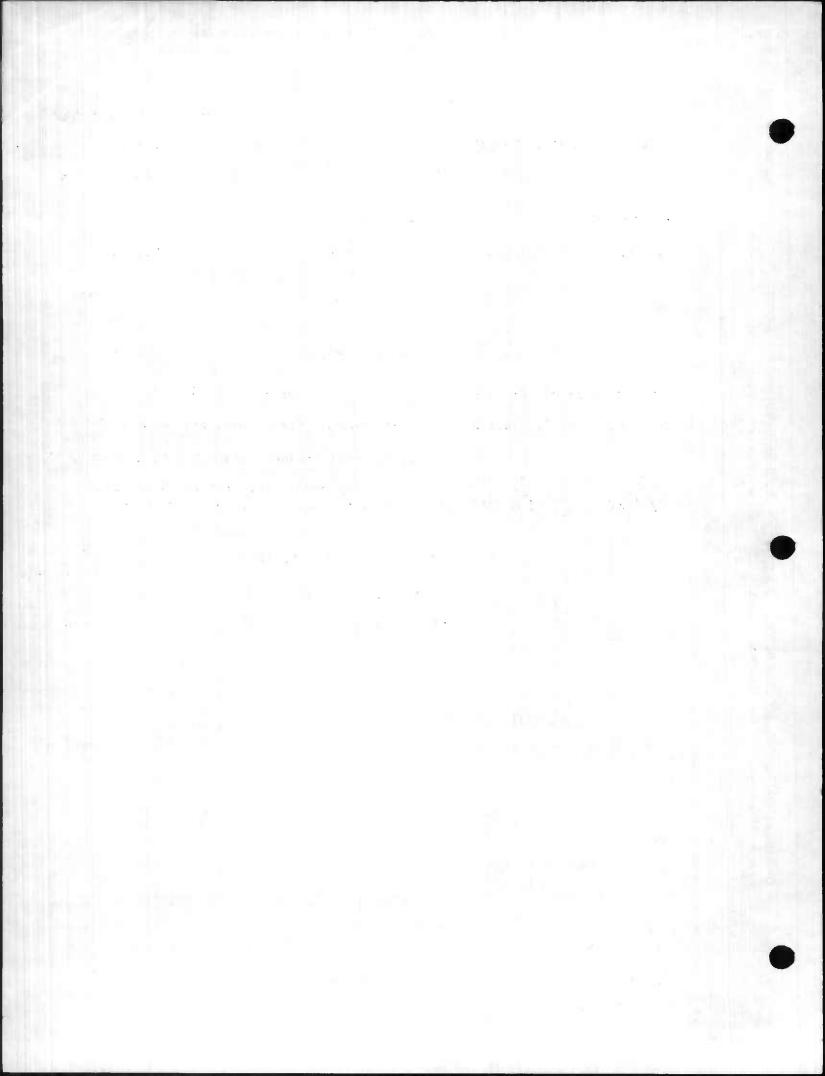
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
GUAN CHAND SURANA 7501 SURRATTS ROAD. CLINTON. M.D.

State Registrar

31. Dete filed (Month, Dey, Year) DEC 2 9 1998

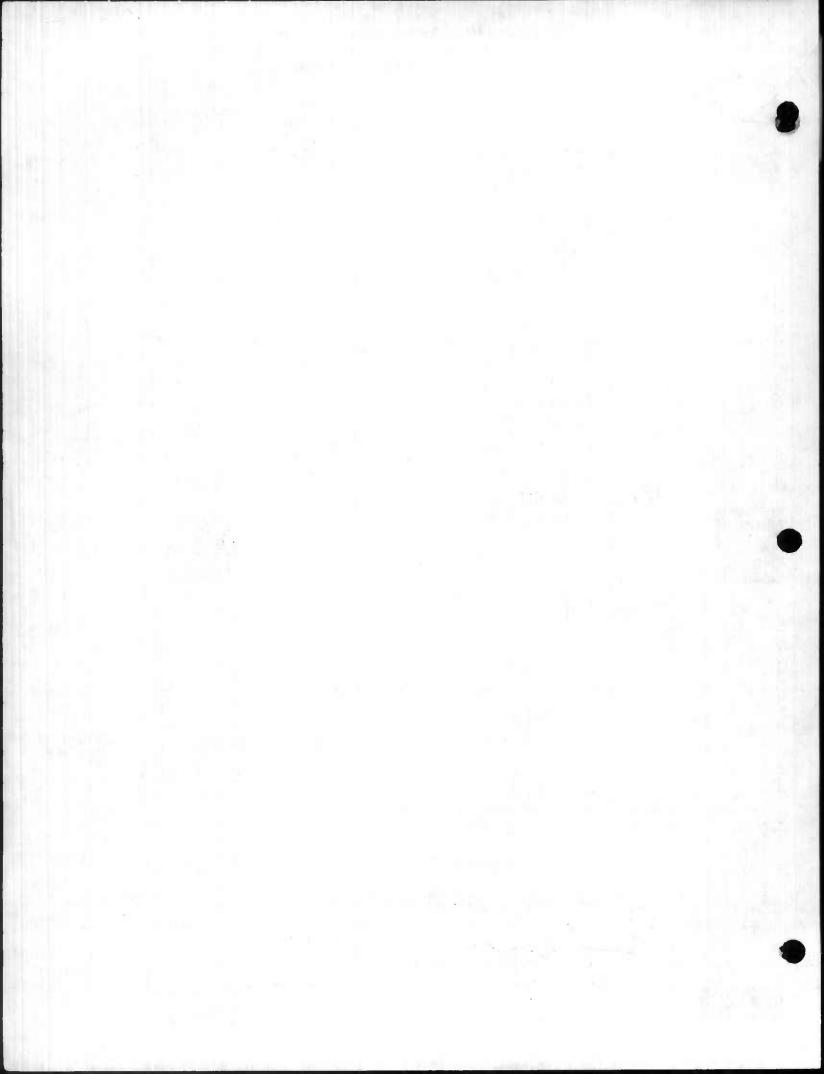
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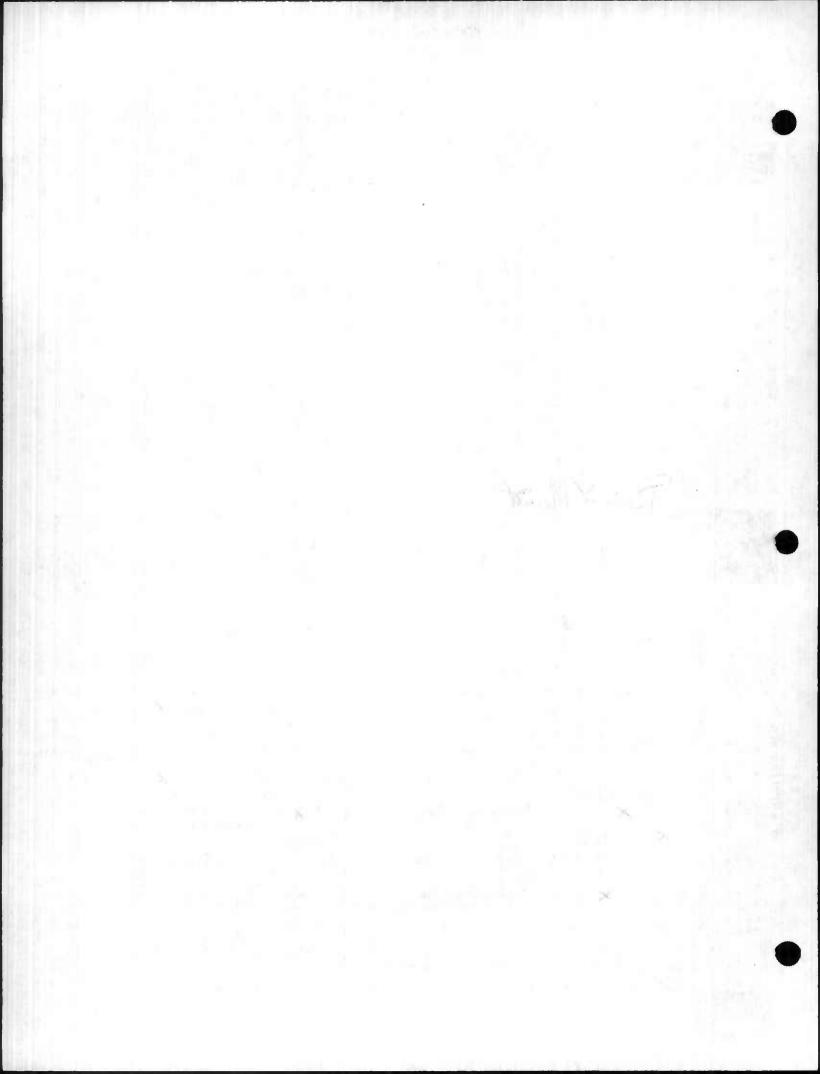
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	Physic	ian	1. Decedent's Neme (First, Middle, La	st) HARTUNG					2. Dete of Deet Month	h Dey	Yeer	3. Tima of Death	
	/Medi	cal	STEPHANIE LYNN		# 0% T	DECEMBE			8:25 AM				
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	پ Funeral Director		MEMORIAL HOSPITAL 5. Sociel Security Number 6. S 214-11-2112 DI		e (In yrs. lest b	irthdey) Yrs.	If Under 1 Yee Months Dey			ALLE(		iece (Stete or Foreign try) AND	
	p ,		Usuel Residence of Decedent		40 00 =								
	anyle show	5	10e. Stete 10b. County		10c. City, Tox						10	Od. Inside City Limits	
	the N	ecto	MARYLAND ALLEGA 10e. Street and Number	NY	Cl	JMBE	RLAND					1 Ñ Yes 2 □ No	
	with with	ā	515 WELCH AVENUE				10f. Zip Code	1502	1"	0g. Citizen of W U.S.		try?	
20	within 72 hours efter death with the Maryland liene. Than "natural", or items 23s or 28s-f show the Med cal Exo item must be notified at	by Funeral Director	11. Marital Status  1. Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give				Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Blace	- America k, White, e	etc.	
9	72 hours		15. Decedent's Ed	Year or Dates:	166	Deced	ent's Usual Occi	ination		16b. Kind of Bu	alaana And	lunta.	
21215-0020	within 72 jiene. r than "nat	Completed	(Specify only highest gra	de completed)	completed)  College (1-4or 5+)  (Give kind of work of life. DO NOT use in NONE			e during most of wor.	NONE		ustry		
pu	be filed tel Hygid d other event, tr	Bec	17. Father's Name (First, Middle, Last)		'			18. Mother's Nam	ne (First, Middle, M				
yla	Mentel Mentel arked c	TOE	PAUL FRED HARTUNG	G JR.				MOLLY	BURK				
Var	Baltimore, Maryland pemit. Peges 1 and 2 should be flie Department of Health and Mentel Hy important: If Health and 12 is merited other any Injury or other traumatic event once.		19a. Informant's Name/Relationship (1	a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street end Number or Rurel Route Number, City or Town									
			MOLLY BURK HARTUNG	G MO	THER 13	GLI	ENVIEW I	RIVE LAVA					
Jor			20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐	Removal from State	cemete	ary, crem	ition (Neme of etory or other pl			20c. Location - (			
Itin			4 ☐ Donation 5 ☐ Other (Specify  21. Signeture of Funerei Service Licen		COMBE			ORY DEC 2	9, 1998	CUMBERL	AND	MARYLAND	
Ba	Depa impo any li		Tools IMs	ist.		MEI		DAMS FUNER		ND MADY	ZI AND		
	Physician		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, An Shock, or heart feilure. List only one ceuse on each line.										
П	/Medical Examiner		Immediate Cause (Fine) disease or condition resulting in death)	CARDIAC	ARRYTI	HEMI	A				S	UDDEN	
		_	resulting in deeth)		Due to (or es e	consequ	ence of):				- 1		
	ned nsit	mlne		b. PNEMONI							1	MONTH	
,	n end fal-tra	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e	consequ	ence of):				i		
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	Se din	-	resulting in death) Last	d									
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0	the school	hys	Part II. Other significant conditions co	intributing to death bu	it not resulting i	n the und	derlying cause g	iven in Part I.	23b. Did tol			the cause of death? ably 4 Unknown	
S, D	es tha igned be de	by P	MENTAL RETARDATI	ON						a ZZNO	3   F100	BOIY 4 OHKNOWN	
Records,	ew requir ss been s 2 should	Completed							24a. Was an perform		ava	re autopsy findings lieble prior to apletion of cause eeth?	
œ	ysician: The i	Com							1 ☐ Ye	s 21 No		Yes 2□ No	
Vita	Iclan: The	Be	25. Wes case referred to medical examiner?					26. Plece of Dee	th (Check only one				
o	E E =	2	1 Yes 2 No	Hospitel: 1 Inpatie			3LI DUA		ome 5 Resider	nce 6 Othe	r (Specify,	)	
	After fune	Certification:	27. Menner of Deeth  1 DNetural 5 Pending  2 Accident Investigetion	28e. Dete of injur (Month, Dey	Year) 28b.	Time of Injury	28c. Inju Wo M 1	iry at ork? ] Yes 2 □ No	28d. Describe ho	w Injury occurre	d	4.4	
DİX	Hospital or Attend 24 hours after deet Funeral Director: stely filled in by the		3 Suicide 6 Could not be determined	28e. Plece of Inju building, etc	ry - At home, fe . (Specify)	erm, stree	et, fectory, office	, fectory, office  28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	ledical										ited. tha cause(s)	
	To the within 2 Comple	Σ	29b. Signeture and title of certifier					f. Dete signed (Month, Day, Year)					
	my		D 09159							ECEMBER	R 29	1998	
	5		30. Neme and address of pelsop who co							500	TIC		
	Stat		DR PAUL SNOW  31. Dete filed (Month, Dey, Year)		3rd S'	L'REE'		RLAND MARY	(LAND 21	.502			
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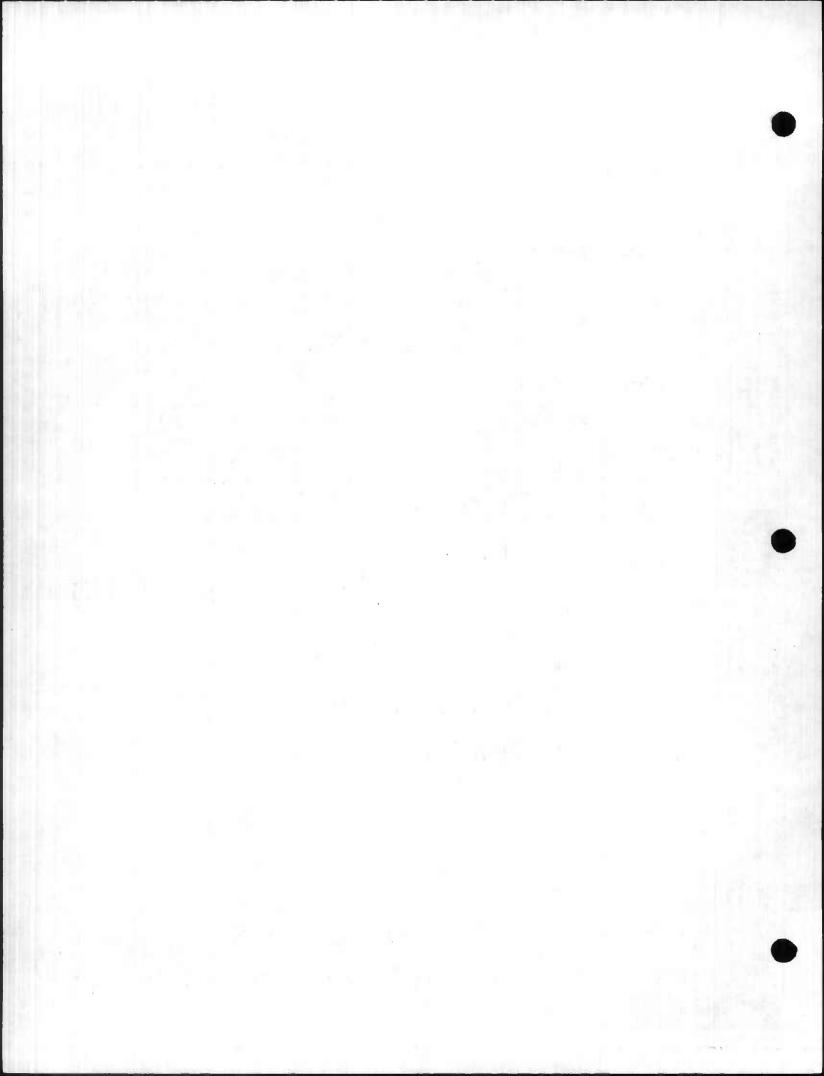
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Too. Stree   10c. County   10c. City, Town or Location   10c. Lease Coy Lumit, Too Street and Tambre   10c. 2pc Code   10c. City Town of Location   10c. City Code   10c. City			1LJM 2KJF	89	Yrs.	Months Deys	Hours Mil	MAY 2	4 1909			
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11. Maries Balais 11. Maries B	rect		GANY	CU	MBERLAI				10g Citizen of	What Coun		
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18. Mother's Name (First, Middle, Ass)   18. Mother's Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Summers)   19. Information Name (First, Middle, Association Name)   19. Information Name (First, Middle, Association)   19. Information Name (First, Middle, Association)   19. Information Name (First, Middle, Association)   19. Information Name (First, Middle, Missociation)   19. Information Name (First, Missociation)   19. Inf	þ		led 1 ☐ Yes If Yes, G	ZXQNo ive				rto Rican, etc.)				
Security   Security	sted				16e. Deced	ent's Usuel Occup	etion	ant in a	16b. Kind of I	d ot Business/Industry		
Technical Name (First, Middle, Last)   JOHN DENNISON   18. Morther's Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers)   The Name First, Middle, Maskins Summers, Middle,	npie				life. D	OO NOT use retire	during most of w	orking				
JOHN DENNISON  199. Informant's NameFleationship (Type, Print)  190. Melling Address (Street and Number or Plaus Raude Number. City or Town, Stells, Zip Code)  200. Method of Disposition 189. Burist 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Removal of Specify 22. Removal of Specify 22. Removal of Specify 23. Perce of Disposition (Name of Commence) or other place) 24. Removal of Specify 25. Perce of Disposition (Name of Commence) 26. Perce of Disposition (Name of Commence) or other place) 27. Removal of Facility 28. Perce of Disposition (Name of Commence) 29. Perce of Disposition (Name of Commence) 29. Perce of Disposition (Name of Commence) 21. Removal of Facility 20. Perce of Disposition (Name of Commence) 21. Removal of Facility 22. Remove and Address of Facility 22. Remove and Address of Facility 23. Perce of Disposition (Name of Commence) 24. Other and Removal of Perce of Commence of Perce			1 11		HOUSE	WIFE						
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ROBERT THOM NEPHEW 453 COLUMBIA STREET CUMBERLAND MARYLAND 21502  20a. Method of Disposition 158	F		hin (Time Brint)		10h Mailie	a Address (Chross					0.71	
20s. Method of Disposition 15 Burlat 2 Disposition (Name at 15 Bur				PHEW								
Topic   Topi		20a. Method of Disposition		20h F	Plece of Dispos	ition (Name of			1			
21. Rignature of Funeral Service Logisses  22. Name and Address of Facility MERRITT - ADAMS FUNERAL HOME 40.4 DECATUR STREET CUMBERLAND MARYLAND  23e. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  Immediate Cause (Final disease, or complications that the cause of each final resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Covo nay dury dusted  Barrier Underlying Clause Disease or shorty Frauthing in death) Last  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Due to (or as a consequence of):  Covo nay dury dusted  Covo nay dury d				Clate				h 1000				
236. Part in disease or conditions and contributing to death but not resulting in the underlying cause given in Pert I.  240. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  250. Pert II. Other eignificant conditions on the pert in the index of the pert index of t				пть	22.	Neme end Addre	ss of Fecility			AND M	ARYLAND	
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Completion of cause of death?   24e. Wes en autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No 1   Yes 2   Yes 2   No 1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes	w		d	eath but not rece	ulting in the un	dodulna anuno oix	on in Dod i	22h Die	4 tobassa was as		Abo cours of death 9	
25. Was case referred to medical exeminer?    1												
25. Was case referred to medical exeminer?    Second   Se		HYPOTHYROIS	sm	CON	SESTIN	IE HE	ART GAN			ava	lieble prior to	
25. Was case referred to medical exeminer?  1   Yes   20   No	Co	CHRONIC	OBSTRUC	TIVE	LUNC	DISEASE		1	Yes 2 No	1	Yes 2 No	
29b. Certifier (Check only one)  29c. Certifier (Check only one)  29b. Signeture end title of certifier  29c. License number  29c. License number  29c. License number  29d. Nursing Home  5   Residence 6   Other (Specify)  28d. Describe how Injury occurred  28d.			Ub-t					ath (Check only	one)			
29e. Certifier (Check only one)  29e. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner as steted.  29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Dey, Year)  DEC 28 1998		27. Menner of Deeth 1 Neturel 5 □ Pending	28a. Dete (Mon	of Injury	28b. Time of	28c. Injury	et				)	
29e. Certifier (Check only one)  29e. Certifier (Check only one)  29b. Signeture end title of certifier  29b. Signeture end title of certifier  29c. License number  29c. License number  29d. Dete signed (Month, Dey, Year)  DEC 28 1998	Ceniic	3 ☐ Suicide 6 ☐ Could n	ned 200. Piece	of Injury - At ho ing, etc. (Specify	ome, farm, stree	et, fectory, office		28f. Location City or To	(Street end Num. own, Stete)	ber or Aurai	Route Number,	
D 26907 DEC 28 1998		Madical B	xaminer: On the bi	asis of examinet	wledge, deeth o tion end/or inve	occurred et the timestigetion, in my o	e, date end plec pinion, deeth occ	e, end due to the urred et the time	cause(s) end m , dete end place,	anner es sto end due to	eted. the cause(s)	
	Σ					29c. Licenso	number		29d. Dete signe	d (Month, L	Dey, Year)	
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)		) 9t.	Side			D 26	907		DEC	28 199	8	
		30. Neme end address of person v	who completed caus	se of deeth (Item	23a) (Type, P	rint)						
31. Dete filed (Month, Dey, Year) 32. Aegistrer's Signeture		DR HARJIT SIDE  31. Dete filed (Month, Dey, Year)		ISHOP WA		AD CUMB	ERLAND N	ARYLAND	21502			



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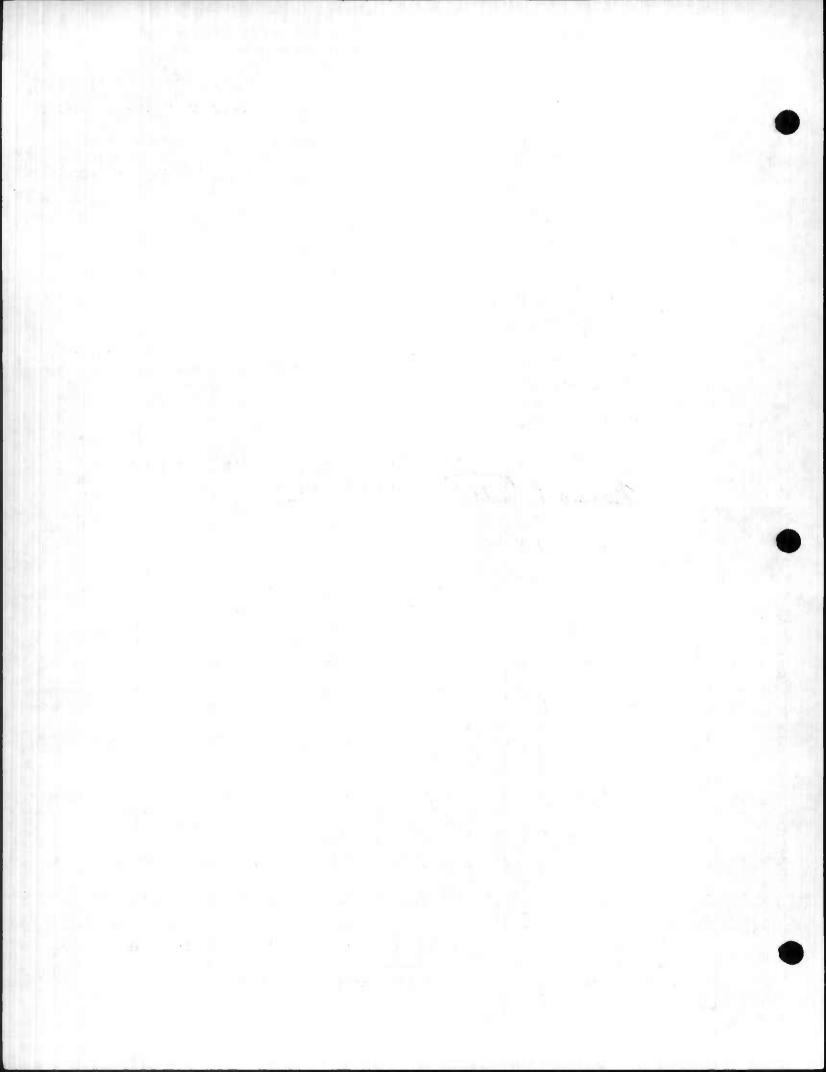
			Certificate of	Death	Reg. No.			
	Dhusisian	1. Decedent's Nama (First, Middle, Last)		2. Date of De Month	eath 3. Time of Death			
	Physician /Medical	Bernard F. Hansrote, Sr.			BER 17, 1998 6:30PM			
	Examiner	4a Facility Nama (If not Institution, give street and number) Sacred Heart Hospital		4b. City, Town, or Location of Deat Cumberland	Allegany			
	Funeral Director	217-18-4640 143 M 2 D F 75	rs. last birthday) If Under 1 Yea Months Days	r If Under 24 Hrs. 8. Date of Bir (Mooth, De	17, 1923 9. Birthplace (State or Foreign			
	yland		City, Town or Location		10d. Inside City Limits			
	vith the Mar or 28a-f al be notified Director	MD Allegany	Cumberland		1 Yas 2 No			
	th with the Maryland 23a or 28a-f show ant be notified at al Director	912 Shades Lane	10f. Zip Code 2150	02	10g. Citizen of What Country? USA			
21215-0020	72 hours after death with the Maryland natural, or thems 23s or 28s-f show deal Examiner must be notified at sted by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Arged Forces?  1 Pyes 2 No lif Yes, Give Year or Dates: WI	X	Hispanic Origin? (Specify Yas or Noban, Mexican, Puerto Rican, etc.)  Specify:	o- 14. Race - American Indian, Black, Whita, atc.  Specify: white			
5-0	natural',	15. Decedent's Education (Specify only highest grade completed)	18a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of working	16b. Kind of Businass/Industry			
121	withir than than	Elementary/Secondary (0-12) College (1-4or 5+)	Retired Machi	nist	B & O Railroad			
	Be dott	17. Father's Nama (First, Middle, Last) Edward Adam Hansrote		18. Mothar's Nama (First, Middla, Meiden Sumama)  Jean May (Kear)				
Maryland	de and and and and and and and and and and	19a. Informant's Name/Ralationship (Type, Print) Martha E. Hansrote-wife	19b. Mailing Addrass (Stree 912 Shades I	et and Number or Rural Routa Numb Lane Cumberland M	ver, City or Town, State, Zip Code) ID 21502			
Baltimore,	Peges 1 nent of He int: if item iry or oth	150 14 a 50 a a 50 a a 50 a a a a a a a a a a	Place of Disposition (Name of cemetary, cremetory or other place) reenmount Cemet	Data Data 12/21	20c. Location - City or Town, Stata Cumberland MD			
Balt	Department Department Important: I any Injury o	21. Signature of Funeral Service Licensee  Comes 7 Scarces		PRYFRUMERAL Home, land MD 21502	, P.A.			
68760,	hilicate be executed on physician and physician and physician and set the burial-transit as the burial-transit as the burial-transit and physician and physi	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events	(or as a consequence of):  (or as a consequence of):	failure n. emphys	Interval Batween Onset and Death  White Constraints of the Constraints			
Box		Part II. Other significant conditions contributing & death but not in		liven in Part 1 23b. Did	tobacco use contribute to the cause of death?			
S, P.O	# 000	Congestive hear	+ fail		Yes 2 No 3 Probably 4 Unknown			
Vital Records,	The lay page 2	Condice and	nale,	Z perfe	s an autopsy ormed?  24b. Were autopsy findings available prior to completion of cause of death?  Yes 20 No 1  Yes 2 No			
of Vita	ysician: s certific director To Be		LI ENVOUTPATIENT 3LI DOA	26. Place of Death (Check only ther: 4□ Nursing Homa 5□ Rasi				
	gran Po	27. Mennef of Death  1 Natural 5 Pending investigation  28a. Data of Injury (Month, Day Year)		ury at ork? 28d. Describe	how injury occurred			
Division	tal or safte and blad in Cert	3 Suicide 6 Could not be detarmined 28e. Place of Injury - At building, etc. (Special Could not be detarmined 28e.)	homa, farm, street, factory, office cify)		(Street and Number or Rural Routa Number, wn, Steta)			
	he Hospi in 24 hou he Funer pletely fil edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinant and manner stated.	nowledge, death occurred at the the the thination and/or investigation, in my	time, date end place, end due to the opinion, death occurred at tha tima,	cause(s) and manner as stated. dete and place, and dua to the cause(s)			
	To the Company	29b. Signatura and title of ceptifier	MD 290.	ise number 459	29d. Data signed (Month, Day, Year)  DECEMBER , 1998			
	nis	30. Name and address of person who completed cause of death (fite	em 23a) (Type, Print)	m Prive,	Cumbuland,			
	State	31. Data filed (Month, Pay, Year) 1998 32. Begistrer's Sign	nature 6. Local	1)	MI			



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State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate c	of De	eath	R	eg. No.	4	1133
Dhaminina		edent's Neme	(First, Middle,	Last)						2. Dete of Dee	th	V	3. Time of Deeth
Physician /Medical		EVELYN	M. HA	RTMAN						Decembe	Day er 15 1	Yeer 998	5:45 p.m
Examiner	44 574	cility Neme (#	not institution, g	give street end nur	nber)			4b. (	City, Town, or L	ocation of Deeth	4c. County		
		Sacred	Heart H	lospital				0	Cumber1a	and	A11	egany	7
uneral rector		lel Security No 34-56-7	10-11-7	Sex · 1□M 2\ F	7. Age (In yrs 62	i. lest birthday) Yrs.	If Under 1 Ye Months De		Under 24 Hrs. Hours Min.	(Month, Dey	Year)	9. Birthp	iece (Stete or Foreign
		Residence of									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Ħ _	10e. S		10b. County			ity, Town or Lo	ocation					1	Od. Inside City Limits
to do		WV Mineral Keyser								1 ☐ Yes 2 ☐ No			
finer must be notified.	10e. S	treet end Num	Street				10f. Zip Cod 2672			1	0g. Citizen of U	Whet Coun	itry?
A A	30	oritei Stetus  Never Marrie  Widowed	od 2□ Married	12. Wes Dece Armed For 1 Tyes If Yes, Giv Yeer or De	rces? 2 ☑ No e		Was Decedent of If Yes, specify C			pecify Yes or No- Ricen, etc.)	Ble	14. Rece - American Indian, Bleck, White, etc. Specify: White	
r, tre Medical Completed		/Speci	15. Decedent's	Education		16a. Dece	dent's Usuel Oc	cupetlo	n		16b. Kind of B	usiness/Ind	lustry
N S	Eier	nentery/Secon		grade completed) Coilege (1:	-4or 5+)	life.	kind of work do DO NOT use ret	ne auni tired)	ng most or won	ang			
1 O		6				Sear	nstress				Garment	Manı	facturing
Be (		ther's Name (I	First, Middle, La	st)				18	. Mother's Nem	e (First, Middle, I	Meiden Sumen	ne)	
To	Da	avid Pi	erce Co	oper					Alta Ma	arie Sau	cer		
mn.		nformant's Na	me/Relationship	(Type, Print)		19b. Meili	ng Address (Stre	eet end	Number or Rui	ral Route Number	, City or Town,	State, Zip	Code)
ž.	Ter	rry L.	Cheshir	e/Daught	er	41	"C" Sti	reet	Kevs	ser, WV	26726		
tto oth	20a. N	athod of Dispo	osition		20b.	Plece of Dispo	sition (Neme of metory or other)	f			20c. Location	City or To	wn, State
7 04			Cremation 3 5 □ Other (Spec	Removal from S	otate				I	Dec. 17	0 1		1.00
를 하	-		erel Service Lic		111		erland (			1998	Cumber	land,	, MD
any ir	•	7	Brian	Low	M	1		-Smi	th Fune	eral Home Keyse		2672	26
100	23a. F	ert1. Enter the	e diseese, or co feilure. List on	mplications thet ce	used the dea	th. Do not ent	er the mode of o	dying, s	uch es cardiac	or respiretory erro	est,		Approximete
ian													tnterval Between Onset and Deeth
dical	immed	dete Ceuse (F	inei	Pos	nirata	ry Fai	luro						Weeks
niner	resulti	ng In deeth)		a. Res		or as a consec	The state of the s					4	weeks
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		ntielly list con- leeding to imm Enter Under (Diseese or in	nediete ying	Ch				11	do Chr	T 17			Vac
cai	Ceuse thet in	tieted events		c. Chr		ympnoc; or as a conseq	ytic lev	uken	па эта	ge IV			Years
Medicai	resultin	ng in deeth) Le	est		200 (0 (0	or as a corrseq	uerice of).						
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of for use													
deteched for us	Pert tt.	Other signific	ant conditions	contributing to dea	ath but not res	sulting in the u	nderlying ceuse	given ir	n Pert t.	23b. Did to	bacco use co	ntribute to	the cause of death?
0 -										1 🗆 Ye	2 2 No	3 Prob	ably 4 Unknown
Completed by										24a. Wes as	n autopsy ned?	ava	re autopsy findings illeble prior to appletion of ceuse leath?
rector, page 2 Be Comp										1 1 Ye	s ZXINo	117	Yes 2□No
0		s case referre	d to medical					26	Place of Deet				7100 2010
To Be	exe	miner? Yes 2[XN		Hospital:	patient 2	ED/Outration	, all no.	Other:		h (Check only on			
	1	nner of Deeth		28e. Dete of	Injury	28b. Time of	I 3LI DUA	- '	-	me 5 Reside 28d. Describe ho			7
		Neturei	5 Pending investigeti	(Month	, Dey Year)	Injury	l v		28d. Describ		,,		
Sa		Accident Sulcide	6 ☐ Could not	be on Diana	of Injury - At h	ome form etr	eet, fectory, offic			28f. Location (St	reat and Numb	ar or Pural	Pouto Number
ed in by the funera Certification:	40	Homicide	determine	building	g, etc. (Specif	fy)	eet, rectory, onic	20		City or Town		er or nurar	node Number,
	29a. C		Certifying P	hysician: To the b	est of my kno	wledge, death	occurred at the	time, d	late and place,	and due to the ca	use(s) and ma	nner as sta	ated.
completely filled		ine)	medical EX	miner: On the bas and manne	er stated.	mon and/or inv	resugation, in my	y opinio	m, death occur	eo at the time, da	ne and place,	and due to	tne cause(s)
woo ≥	29b. Si	gnature and ti	tle of certifier	10		A .	29c. Lice	ense nu	mber	29	d. Date signer	d (Month, D	Day, Year)
		(noth	h W	Ulm	Non	11-1	D-	-175	26		Decemb	er 16	, 1998
	30. Ner	n and eddres	s of person wh	completed cause	of death (item	n 23a) (Tune							. = 0.0
W .	1	11						- 1 m	nd im	21502			170.0
		e filed (Month)	lanna, M			n Drive	e Cumbe	FLTa	ind, MD	21502			
State	n		1000	122 MARA	gistrer's Signa	ALUI O							100



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State of Maryland / Department of Health and Mental Hygiene 9 8 4 1 3 4

		Certificate of	of Death	R	eg. No.	7 7	1109	
	Decedent's Neme (First, Middle, Last)			2. Dete of Deat		Vees	3. Time of Dear	
ician	LILLIAN W. HICKMAN			Month Decembe:	r 19, 1	Year 1998	2:21 P.1	
dical niner	4e Facility Neme (Il not institution, give street and number)		4b. City, Town, or L	1	1	y of Death		
mei	SOUTHERN MARYLAND HOSPITAL		CLINTON				orge's	
al l	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	(day) If Under 1 Ye		8. Dete of Birth			-	
	1∏M 2FJE	Months Da		Nov. 19	Year)	Coun	place (State or Fornity) ngton, D.C.	
	099-20-6879 77  Usuel Residence of Decedent			NOV. 19	, 1921	Wastilli	igcon, D.C.	
	10e. Stete 10b. County 10c. City, Town	or Location				1	Od. toside City Lir	
5							1 🖫 Yes 2 🗆	
Ş	3	at Pleasan						
Funeral Director	10e. Street and Number		1	0g. Citizen of				
ē	710 66th Avenue	20743		United	i Stai	tes		
	11. Maritai Stetus 12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of If Yes, specify C	of Hispanic Origin? (Sp Juban, Mexican, Puerto	pecify Yes or No-		ce - Americ		
2	1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 💆 No	1 ☐ Yes 2 🖾 N					Olo.	
	3 □ Widowed 4 □ Divorced Year or Dates:	10 103 2201	чо орвану.		Specif	B1	lack	
	15. Decedent's Education 16a. C	Decedent's Usuei Oc	cupation	16b. Kind of Business/Industry				
	(Specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4or 5+)	Give king of work do life. DO NOT use rei	ne during most of worl tired)	orking				
	12	Nurses Ass	sistant		Priva	te		
	17. Father's Neme (First, Middle, Last)		18. Mother's Nem	e (First, Middle, M	Maiden Sumer	ne)		
	Levi Brown		Lucy	Colbert	lbert			
2		Mailing Address (Sta	eet and Number of Ru			State 7in	Code	
						2074		
		Disposition (Name of	nue, Seat					
	1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removei from Stete	cremetory or other	plece)		20c. Location	- City or To	wii, Siela	
	4 □ Donetion 5 □ Other (Specify) Harmony	Memorial Pa	ark 1	2/28/98	Landov	er, M	D	
	21. Signature of Funeral Service Licensee	22. Name end Ad		and the				
	Make I Strugget TIT		FUNERAL HO				D 0	
÷	23a Part Enter the disease, or complications that caused the deeth. Do no	4001 Ber	nning Road	or respiretory err	vasning	ton.	D. C. Approximate	
	shock, or heert feilure. List only one cause on each line.		aying, abon or our our	or roop notory on	001,		tnterval Between Onset and Death	
	immediate Cours (Final	1						
disease or condition resulting in deeth)  a. CORNAC DISCASC								
_	Due to (or es a co	onsequence of):				1		
Examiner						i		
Acti	Sequentially list conditions,  Due to (or es e co							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or es a co							
edical	that initiated events resulting to death) Last Due to (or es a co	nsequence of):					1	
Me						1		
37	0.					1		
SICI	Pert tl. Other significant conditions contributing to death but not resulting in t	he underlying cause	given in Pert i.	23b. Dld to	bacco use co	ontribute to	o the cause of de	
Physician					es 2□ No			
Dy r					20140	2		
				24a. Wes e	n autopsv		ere autopsy findin	
Completed				perform	med?	CO	ailable prior to impletion of cause	
d L						of	death?	
,				TUY	or Els e	10	Yes 2 No	
9	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only on	e)			
9	1 Yes 2 No Hospital: 1 Inpatient 2 R/Outp	eatient 3 DOA	Other: 4 Nursing H	ome 5 Reside	ence 6 🗆 Oti	her (Specif	y)	
	27. Manner of Death  1 Chapter 5 Deading (Month, Day Year)  28b. Tin (Month, Day Year)	me of 28c. II	njury at Work?	28d. Describe ho	w injury occu	теб	The state of	
Certification:	1 ☑Neturei 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation							
2	3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, ferm	СӨ	28f. Location (St	reet and Num	ber or Rura	Il Route Number,		
5	4 ☐ Homicide building, etc. (Specify)			City or Town	, State)			
	29a. Certifier 121 Certifying Physician: To the best of my knowledge of	south ecourand at the	time data and stan-	and due to the o			inted	
edical	(Check only 2 Medical Examiner: On the basis of examination and/							
8	and marrier states.	00-11-			04.0-11	-1 (0.0	O KI	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye								
	7 mm	120	) 57/	7	CILMR	12 2	4. 199,	
	30. Name and address of person who completed cause of death (item 23a) (Ty	ype, Print)	^			1	1	
	DO TIFFEY SCIMAN 15)	5 Rall	PKIT PM	20 14.	ATTO	11//	MO 10	
	31. Date filed (Month, Dey, Year) 32. Registrer's Signeture	1 MAIL	-67 10	4, 1/4	7- [1] 0	146	1.1 1	
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				Cer	tificate of	Death	В	eg. No.		100
		1. Decedent's Neme (First, Middle, La	st)				2. Dete of Deel	h Day	Yeer	3. Time of Deeth
	Physician /Medical	WILLIAM	HARRIS				PECEMB		1998	02:08
	Examiner	4a Facility Nema (If not institution, giv	a street and number)			4b. City, Town, or I	ocation of Death	4c. County	of Death	
40		3703 WAL	NUT LANE			SUITLA	ND	PRINC	E G	EORGES
	Funeral	Sociei Security Number     6. S			If Under 1 Yee Months Days		8. Dete of Birth (Month, Day,	Year)	9. Birthple	aca (Stata or Foreign
	Director		<sup>™</sup> <sup>2□</sup> F 72	Yrs.			March 7		rewe,	, Virginia
	pus *	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10	Od. Inside City Limits
	Aarylar r show									1, ☐ Yes 2 ☐ No
	vith the Mar to 28s-1 st be notified Director	Maryland Prince Ge	eorge's Sul	tland	10f, Zip Coda		1	Og. Citizen of W	What Count	to/?
	23a or	3703 Walnut Lane								,,,
	ifier death with the Maryland r flems 23a or 28a-f show finer must be notified at Funeral Director	11, Marital Status	12. Wes Decedant Evar in U	,S. 13. V	Ves Decedent of	Hispanic Origin? (S	pecify Yes or No-	USA 14. Race	e - Amarica	an Indian,
0		1 ☐ Never Marriad 2 Married	Armed Forcas? 1 ☑ Yes 2 ☐ No			ben, Mexicen, Puert	o Rican, etc.)		k, White, a	itc.
020	by	3 Widowed 4 Divorced	If Yes, Give Yaar or Dates: 1945	-65	Yes 2 No	Specify:		Specify	blac	ck
5-0	"natural", or its adical Examina leted by Fui	15. Decedent's Ec	lucation	16e. Deced	ent's Usuel Occu	upetion a during most of wor	tina	16b. Kind of Bu	siness/Ind	ustry
21215-0020	9 1 5	Elamantary/Secondary (0-12)	Coilege (1-4or 5+)	lifa. E	O NOT usa retin	ed)	All 19			
	Hygiena. Hygiena. ther than ant, tre M		1+	Diese	el Engin	eering In				;
Pu	tal Hyginal Hy	17. Father's Neme (First, Middle, Last)					ne (First, Middle, I	Maiden Surnem	a)	
× a	should be nd Mental marked o urnatic av	Eddie Harris				Lucy An	n Perry			
Maryland	2 a le	19e. Informent's Name/Reletionship (	Type, Pnint)	19b. Meilin	g Address (Stree	et end Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)
	Health Health other tr		vife		Walnut sition (Neme of	Lane Suit				01-10
0	Pagas 1 nent of H int: If ite iry or ot	20a. Mathod of Disposition 1 □ ★urial 2 □ Cremetion 3 □		cemetery, cren	netory or other pi	eca)	Dete	20c. Location -	City or 1 ov	MI, Steta
Pa Pa	Pa Int:	4 □ Donetion 5 □ Other (Specify	LAL.		Nation		12-23	Arlingt	on, V	Virginia
Bal	permit. Pa Department Important: any injury once.	21. Signature of Funarai Service Licar	500	22	. Neme end Addr		RSHALL'S	FUNERAL	HOME	3
	40240	XP /110	ushall	43	308 Suit	land Road	Suitla	nd, MD	2074	46
-		23a. Part Enter the disease, or com show, or heart feiture. List only	olicetions thet caused the deet one ceuse on each line.	h. Do not ente	er the mode of dy	ring, such as cerdiac	or respiretory err	est,		Approximeta Intervei Between Onset and Deeth
	Physician /Medical	Immediate Cours (Final						01114	1	
	Examiner	Immediate Cause (Final disaasa or condition resulting in deeth)	. HYPERTENSIVE	E ARTE	KIOSCLE	rotic a	SAVOINE	CULAR	VISE	ASE
0				or es a conseq						
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_6	death certificate be executed e attanding physician and rd for use as the burial-transit siclaryMedical Examir	Sequentielly list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury	Dua 10 (d	or as a conseq	uence of):					
68760	sicia bur	Ceuse (Diseese or Injury thet initiated events	C. Duo to (c							
89	ficate be physicie as the bu	resulting in death) Last	Due to (o	or es e consequ	dance of):					
Вох			d							
_ 0	The law requires that the death co zate has been signed by the attend page 2 should be detached for us. Completed by Physiclan/	Part II. Other significant conditions of	ontributing to death but not res	uiting in the ur	ndertving cause o	iven In Pert I.	23b. Did to	obacco use cor	ntribute to	the cause of death?
P.0	thad by the tached	04110-10 0-	2005-				1 🗆 Y	es 2 No	3 Prob	ably 42 Unknown
	s that aned b se deta by Pl	CANCEL OF	ROSTATE							7
Records,	w requires that been signed i should be det						24a. Was a perfor	n autopsy	24b. We	re autopsy findings allable prior to
သို့	as be 2 sh								con of d	mpletion of cause death?
	The law page 2						104	88 2 No	10	Yes 2 No
	cartificata rector, pag	25. Was case referred to medical				26. Place of Dea	ath (Check only or	10)		
of Vital	Physician: this cartific ral director, TO Be (	examiner?	Hospital:	ER/Outpatien	t 3□ DOA O	ther: 4 Nursing H	loma 5 X Raside	ence 8 Oth	er (Specify	()
	6 6 5	27. Minner of Deeth	28e. Dete of tnjury (Month, Day Year)	28b. Time of injury	28c. Inj	ury at	28d. describe h	ow injury occurr	ed	
0	Attending F r death. Actor: After by the funar iffication:	1 Naturei 5 Pending 2 Accidant Investigation								
Division	ar de by the by the tific	3 ☐ Suicide 6 ☐ Could not be determined	9	28f. Location (S		er or Rural	l Routa Number,			
	tel or Attanding P rs shar death. al Director: Attar it led in by the funare Certification:	4 E Homodo	building, etc. (Specif	y/			ony or rom	, 0.0.0)		
	hound in y		ysician: To the best of my kno niner: On the basis of examina							
	To the He within 24 To the Fu complete	one)	and manner stated:	) I I I I I I I I I I I I I I I I I I I						
	With To the Com	29b. Signature and title of certifier	114 / Un.	40	29c. Licer	nse number		9d. Date signer		
1		Kund	VI TOUNS	JU DI	HOSPITAL DRIVE, CHEVERLY, MARYLAND 18					
11	2)11/1	30. Name and eddress of person who	complaint cause of death (tex	23e) (Type, I	Print)	1 00	1.1.00	2154	A . 4 . 1	20781
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	State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signe	otura	You do	-	/		•	
	Registrar	DEC 2 1 1998	1	1	The state of					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Roginald Hawken > 5:36 pm December 1998 15 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** M 2□ F Days Hours Months 578-70-9755 45 Director June 23, 1953 Washington, D.C. Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location r than "natural", or frame 23a or 28a-f ahow to be decical Examinar orast be notified at 10d. Inside City Limits 1 Yes 2□ No Directo Maryland | Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Harry S. Truman Drive, apt.#12 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i filed within 7 i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Hasith and Maniel Hygiers Important: if Nem 27 is marked other the enty fillury or other traumatic evant, that 11th Supervisor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 2 Warren Hawkins Aisha Garris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Hawkins/Wife 123 Harry S. Truman Drive, #12, Upper Marlboro, Maryland 20774 20s. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 12/21 20c. Location - City or Town, State 1 ☐ Burial 2 ☼ Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 1998 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fscility J.B. Jenkins Funeral Home Percon 7474 Landover Road, Landover, Maryland 20785 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. 23a. Part1. Enter the uses shock, or heart failure. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Immunodetriency Syndone physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the deeth certificets be axecuted Due to (or as a consequence of): Box 68760. Physician/Medical at initiated events sulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 €Unknown P been significant 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? Completed 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No

Division of Vital Records, P.O. al or Attending Physician: T a after death. If Director: After this certificat of in by the funaral director, p 8 Medical Certification: To

To the Hospital or within 24 hours at To the Funeral Di completely filled in State

**DHMH 16 Rev 6/95** 

Registrar

5 Pending

investigation

6 Could not be

27. Manner of Death

1 S Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

29a Certifier (Check only one)

> 18111 22. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Hospital: 1-12 Inpatient 2 □ ER/Outpatient 3 □ DOA

28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Prince Philip Once #210 Olney, MD 20832

28c. Injury at Work?

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

042777

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

.

SEC 1 1 330

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marie Hamilton Rosa 21, 1998 9:38AM December 4e Facility Nama (ff not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 5. Sociel Security Number 1 M 200 Months Yrs. Index, VA. May 6, 213-26-7263 Usual Rasidance of Dacedani 67 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Accokeek Maryland Prince George's 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20607 USA 2801 Marshall Hall Rd. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indien. 12. Wes Decedent Ever in U,S. Armed Forcas? Bleck, Whita, atc. 1 ☐ Yes 2XXNo If Yas, Give Year or Dates: 1 ☐ Nevar Married 2 ☐ Merried Specify: White 1 ☐ Yas 2 ☐No Specify: 3√2Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) N/A Disabled 5th 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Fether's Nama (First, Middla, Last) Wesley Thomas Scott Fannie Mae Pates 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) Albert H. Hamilton/Son Same as item 10 20b. Place of Disposition (Nama of camatary, cramatory or other place) Date 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Ramoval from Stata Metropolitan Crematory 12/21/98 4 ☐ Donetion 5 ☐ Other (Specify) Alexandria. Va. 21. Signatura of Funeral Servica Licensea 22. Nama and Addrass of Facility Kalas Funeral Hill Rd. Oxon George P. Md. 20745 23d. Pek1. Enter the diseese, or com shock, or heart failure. List only tions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, cause on each line. Approximate Interval Batween Onset and Deeth Immediate Cause (Finel Unknown Pneumonia disaesa or condition resulting in death) Dua to (or as a consequence of): Unknown Respiratory Failure Sequentially list conditions, if any, laading to Immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Chronic Obstructive Lung Disease Unknown Due to (or as a consequenca of): Non small cell of lung Unknown 23b. Did tobacco use contribute to the cause of death? Pert If. Other elanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Panding 1 ☐ Yes 2 ☐ No invastigation

that the death certificate be executed physicien end the burial-transit Division of Vital Records, P.O. Box 68760, 80 esn signed by the er page 2 s certificate Hospital or Attending Physician: 24 hours efter deeth. funeral director, this After efter deet Director:

Physician Allegical

**Examiner** 

**Physician** 

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show sub injury or other traumatic event, the Medical Example: must be notified an once.

Baltimore, Maryland 21215-0020

/Medical

1 ☐ Yes PNO 27. Mannar of Deeth XX Netural 2 Accidant

3 Suicida

23st. Certifier

4 Homicida

(Check only one)

Physician/Medical P Completed Certification: To

Examiner

filled in by A 24 hou. completely To the To the To the

Medical

State Registrar 29b. Signature and title of certifier

29c. License number D50454

13. Certifying Physician. To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) December 21, 1998

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Nama and addrast of part on who complated ceusa of death (Itam 23a) (Type, Print)

6 Could not be

1328 Southern Ave. S.E. #202 Washington, D.C. 20032 Arastoo Yazdani, M.D.

31. Data filad (Month, Day, Year) DEC 2 1 1998



28e. Piece of Injury - At home, farm, straat, fectory, office building, atc. (Spacify)

328 1 2 330

Wilder mount will all

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 7:36 AM Н. 1992 NECEMPE 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yes May 12, 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys Hours 1⊠M 2□ F Yrs. 82 1916 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 4113 56th Avenue 20781 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. I ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: W W Ⅱ 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Printer Newspaper Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Walter H. Horn, Mary Anna Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Anna Horn - Wife 4113 56th Avenue, Hyattsville, Maryland 20781 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/23/98 Brentwood, Maryland 22. Name end Address of Fecility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the displace, or complications the caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart ail/re. List only one cause on each line. Approximete Intervai Between Onset end Deeth Due to (or es a consequence of): Sendo obstruction Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown brother years

**Physician** /Medical Examiner

been signed by the a should be datached f

page 2

director.

completely

Be

Certification: To

Medicai

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23s or 28s-f show folics! Examiner must be notified at

th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical.

27

or other

72 hours aftar

filed within

Pagas 1 and 2 should be 1 nent of Haalth and Mental I

Director

Funeral

Completed by

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Walter

5. Sociel Security Number

578-09-9410

10e. Street end Number

11. Meritel Stetus

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical by Completed

Immedieta Cause (Finel diseese or condition resulting in deeth)

2KNO

24a. Wes en eutopsy performed?

worleval 25. Was case referred to medical 1□ Yes 2□ No

Hospital: → Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred

5 Pending Investigation 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Certifier

i 🗲 prifying Physictan: To the best of my knowledge, deeth occurred at the time, data and plece, end due to the cause(s) and mannar as stated. 2 Medical Examiner. On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

perior Lane

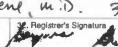
1 Yes 2 No

24b. Were autopsy findings evelleble prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar

Madalene 31. Dete tiled (Month, Day, Year)
QEC 2 3 1999



ill iD

who completed cause of death (Item 23e) (Type, Print)



**DHMH 16 Bay 6/95** 

Records,

P.O. Box 68760,

The law requires that the death cartificate be axecu

certificata Division of Vital or Attending Physician:

Aftar this within 24 hours after death. To the Funeral Director: A

Hospital

To the

in by tha funaral

27. Menner of Deeth 1 Weturel 2 Accident

3 Suicide 4 ☐ Homicide

6 Could not be determined

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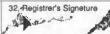
### Piease Type or Print in Black Indelibie ink. Assure Aii Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death December 1 **Physician** 12:42 PM 1998 JAMES LESTER HUNTER /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Devs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) **Funeral** 1XM 2□ F Deys 59 578-52-5521 Director April 9, 1939 Washington, D.C. Usuel Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ehov the Medical Example: must be notified at 1X Yes 2 □ No Directo Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3105 - 82nd Avenue 20785 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11 Maritel Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ No 1 ☐ Never Married 2 ☑ Married Specify: Black altimore, Maryland 21215-0020 1 Yes 2X No Specify: p 3 Widowed 4 Divorcad Year or Dates: "naturel", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Painter Private 12th Peges 1 and 2 should be filed nent of Heelth and Mental Hygi mt: If item 27 le marked other 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Lester B. Hunter Eleanor Terrell 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Mary E. Hunter/Wife 3105-82nd Avenue, Landover, Maryland 20785 20b. Pieca of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 12/26 1⊠ Burial 2 □ Cremetion 3 □ Removel from State permit. Pege Department of Important: If any Injury or phose. Harmony Memorial Park 1998 4 ☐ Donetion 5 ☐ Other (Specify) Landover, Maryland 21. Signeture of Funerel Service Licensee J. B. JENKINS FUNERAL HOME Verce. 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner requires that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of) USB BS jo signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 2 50No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy page 2 certificate † D Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical Be 26. Plece of Deeth | Check on | one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 115 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Menny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 26d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation Mural 2 No Acci ent 3 Suicide 6 Could not be determined Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated. completely (Check only one) On the basis of exam and manner stated. To the To the To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Year)

DEC 2 3 1998





Rakesh Arora, MD, 14300 Gallant Fox, Suite #222, Bowie, Maryland 20715

literate a

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** HELEN LOUISE HALEY DECEMBER 20,1998 ocation of Death 4c. County of Death 5:45 AM · /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) **Funeral** Days Hours 1□ M 2□ F Yrs. Director 577-24-5392 Usuai Residence of Decedent 86 August 1, 1912 Virginia with the Marylenc r 28a-f show 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Prince Georges Directo Hyattsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examines must be a permit. Peges 1 and 2 should be filed within 72 hours efter death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 29a
any Injury or other traumatic event, the Medical Experimental once. Funeral 1001 Chillum Road 20782 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Yaar or Dates: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Howard University 11th Medical Technician 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be James Hogan Audrey Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) James L. Haley, Sr. 1001 Chillum Rd. Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 12-26-98 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral HOme, Inc. 23a. Pairk. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, struck, or heart feiture. List only one cause on each line. 20011 Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical uspiratory Examiner Examiner Dreumoni physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): 416 certificate be Physician/Medicai Dua to (or as a consequence of) 888 eas 980 23b. Did tobacco use contributs to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. P.0. 3 Probably 4 Unknown á 1 ☐ Yss 2 ☐ No signed b p 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy peed completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to madical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA this funerai 28c. Injury at Work? Certification: 27. Menger of Death 28d. Describe how injury occurred 28b. Tima of 28a. Date of Injury (Month, Day Year) After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident Invastigation after deet Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 5 Hospital Centrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinér: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the To the To the 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number Was n Ruhol December 20, 1998 133372 RASHID KAGUAI -NAINI 30. Nama and eddress of the n who completed cause of death (Itym 23a) (Type, Print) Ý Suit 324 209-1 31. Date filed (Month, Deyl Year)

32/Registrar's Signature

DHMH 16 Rsv 6/95

State

Registrar

DEC 2 3 1998

Charles May

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Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

rail, or items 23a or 28a-f ahow Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Haalth and Mental Hygiena. important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examines must once.

Baltimore, Maryland 21215-0020

Director

Funeral

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Be Completed

Examiner physician and the burial-transit Physician/Medical To the Hospital or Attending Physician: Inataw requires and some some within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as Be Completed by Medical Certification: To

The law requires that the death certificate be asscuted

Division of Vital Records, P.O. Box 68760,

Johnson, Roscoe

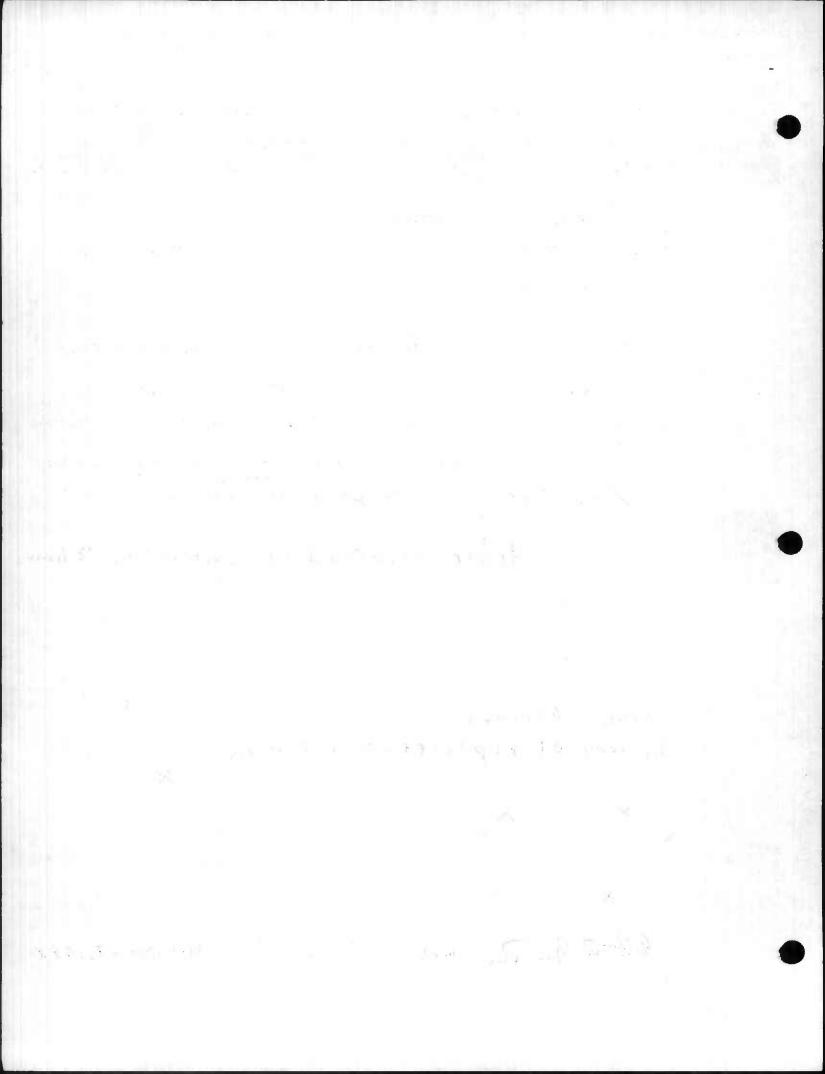
					1					
Part II. Other significant conditions con	tributing to death but not ras	ulting in tha undarlyin	g causa givan in Part I.	23b. Did tobacco use co	ontribute to the cause of death?					
history o	f ruptu	red av	rtic anen	24e. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?					
25. Was cese rafarred to medical			28. Plece of De	eath (Check only ona)						
axaminar? 1 ☐ Yas 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3	Othor		5 Rasidanca 6 Othar (Specify)					
27. Mannar of Death Natural 5 Panding Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work?	28d. Dascribe how injury occur						
3 Suicida 6 Could not be datarmined	28a. Place of Injury - At he building, atc. (Specif.	oma, farm, street, fac y)	tory, office	281. Location (Street and Numi City or Town, Stata)	281. Location (Street and Number or Rural Routa Number, City or Town, Stata)					
29a. Certifler (Check only one)	ician: To the best of my kno er; On tha basis of axamine and mannar stated.	wladge, deeth occurr tion and/or invastigat	ed at tha time, dete end plac ion, in my opinion, daath occ	e, and dua to tha ceusa(s) and mo urred at tha tima, dete and plece,	enner as stated. and dua to tha cause(s)					
29b. Signatura and titla of certifiar			29c. Licansa number	29d. Data signe	d (Month, Day, Year)					

December 27, 1998

State Registrar 30. Nema and address of person who completed of death (Item 23a) (Type, Print) 370

La 31. Data filed (Month, Day, Yaar) 32. Ragistrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** 1248 December Virginia Johnson 24 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 24 Hrs. 6. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 M 2 K **Funeral** Months Deys Yrs. 213-14-6148 83 Aug.29 1915 Maryland Director Usuei Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b County 10d. inside City Limits 28a-f show 7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Maryland Directo Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 14. Race - American Indian, 4522 Whitehaven Road 21856 permit. Pagas 1 and 2 should be filed within 72 hours after death 1 Department of Haelth and Mental Hygiena. Important: If them 27 is marked other than "naturel", or items 23 eny injury or other traumatic event, the Medical Exercited mans. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Domestic None 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) James Ernest Shiles Josephine Price 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e, informent's Neme/Reletionship (Type, Print) Madelyn Shiles (Niece) 7591 Buckman Ave.Salisbury, Md.21801 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete 12/30/98 Salisbury, Md 1 Burlei 2 Cremetlon 3 Removel from Stete 4 Donetion 5 Other (Specify) Green Acres 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee eny li Stewart Funeral Home 821 West Rd.Salisbury, Md.21801 23e. Pert1. Enter the u seese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset and Deeth **Physician** Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical 4 DASS Examiner Examiner The law requires that the death certificate be executed physician and the burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ŏ 23b. Did tobacco use contribute to the cause of death? ed by the a Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed peen s 188 1Li Yes 2 No cartificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifics staly filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient Certification: To 3 DOA 28e. Dete of injury (Month, Dey Year) 27. Menger of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide within 24 hours aft To the Funeral Dis complataly filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 Mo in

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Drune, Sples and 21804

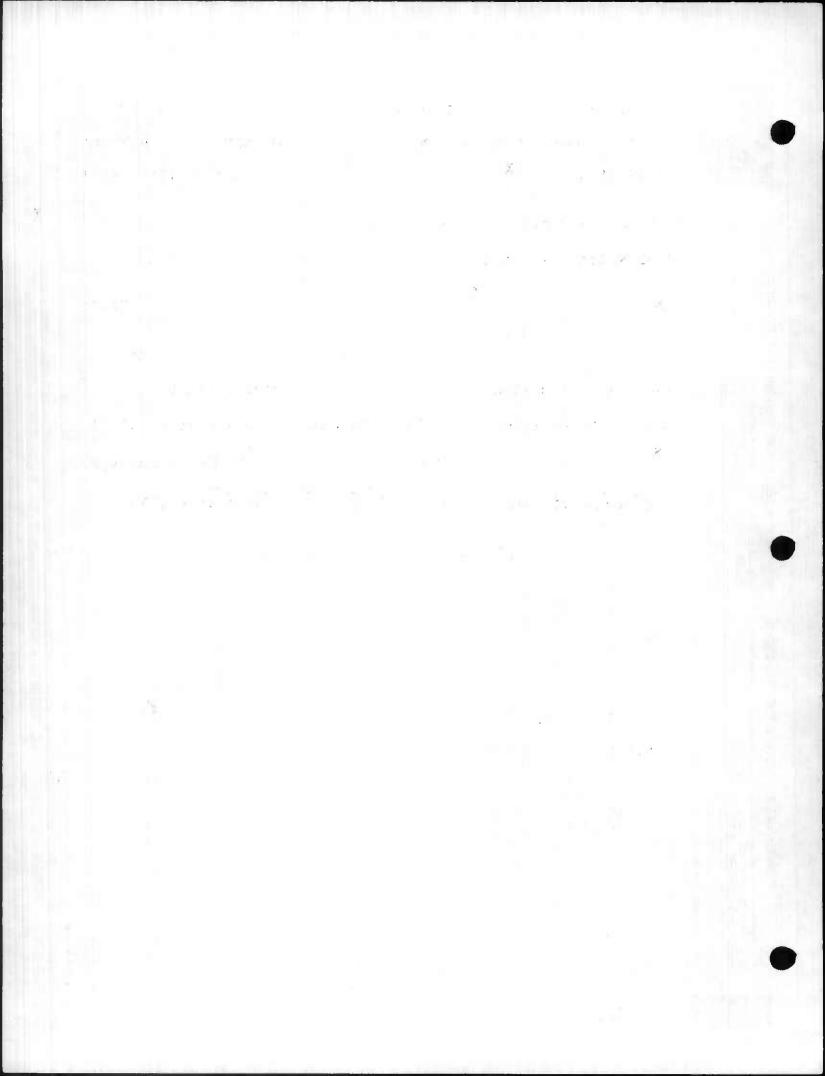
State Registrar MATICINS (31. Dete filed (Month, Dey, Year)

DEC 2 8 1998

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

1104

32. Registrer's Signature

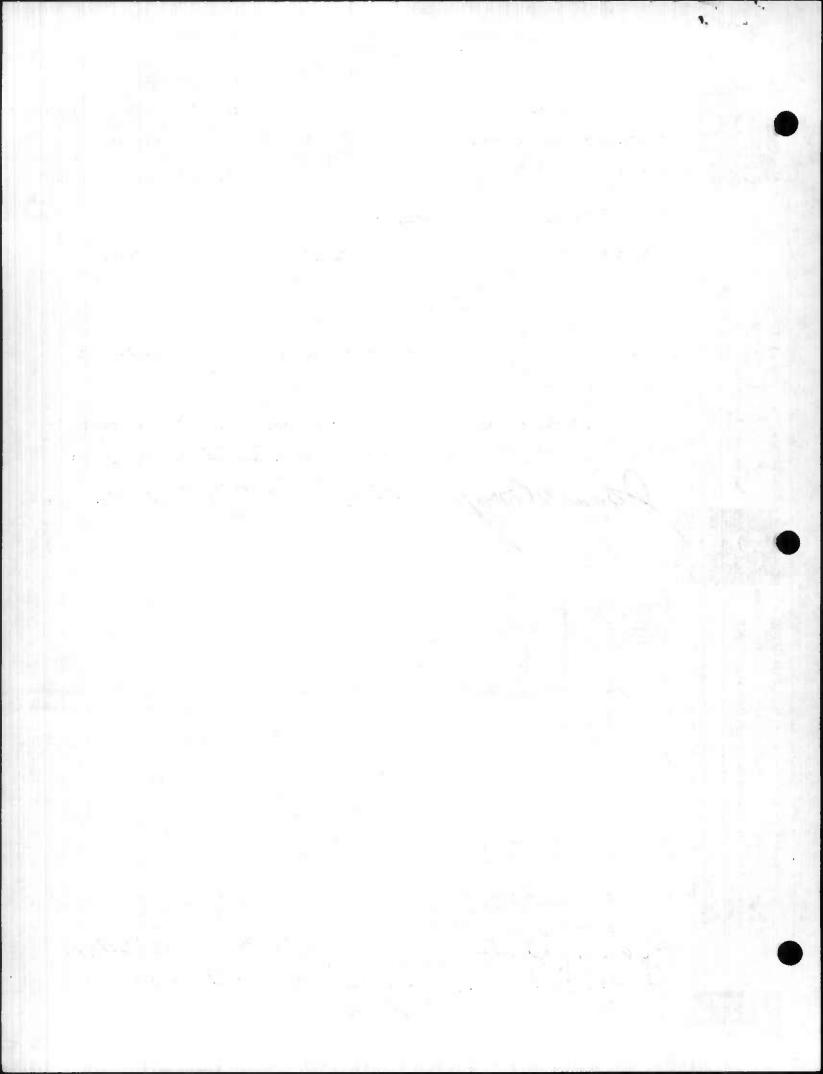


Amended Item #20b per F. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 12/28/98 Carroll County H.D. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Veer Ernest O. Jenkins Dec. 25 1998 /Medical 11:05 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth **Examiner** 4c. County of Deeth Westminster Nursing Home Westminster If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year 6 Sax 7. Age (In yrs. lest birthdey) **Funeral**  Birthplece (State or Foreign Country) Deys 1 XM 2□ F Vrs 220-07-1684 87 Director Oct. 3, 1911 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified Director Maryland Carroll Westminster 1 ☐ Yes 2 X No the 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ģ 143 Bond Street 238 21157 Funerai United States Herra 2 12. Wes Decedent Ever In U,S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Yeer or Detes: WW II Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11 Maritei Status Rece - American indian, Black, White, etc. efter 1 Never Married 2 Married 6 altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 X Widowed 4 □ Divorced Specify. natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elamantery/Secondary (0-12) Coilage (1-4or 5+) Unknown Carpenter Self-employed 17. Fether's Neme (First, Middla, Last). 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental marked Ernest H. Jenkins Annie E. Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 of Department of Health ar important: if item 27 is any injury or other traughts. .09 143 Bond Street Apt. A Westminster, MD 21157
of Disposition (Nema of 12730/08 20c. Location - City or Town, State 12730/08 20c. Location - City or Town, State Mr. Allan W. Jenkins Son 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Freedom Cemetery Dec. 30 Sykesville, MD 21. Signeture of Tunerel Service Licensee 22. Name end Address of Fecility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 nt1. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final meumous die ese or condition resulting in deeth) **Examiner** Dua to (or es a consequence of): Examiner The law requires that the deeth certificate be executed burial-transit Sequentially list conditions, if eny, leeding to immediate ceusa. Enter Underlying Cause (Disease or Injury the Injuryal Cause) Due to (or es a consequence of): P.O. Box 68760. Physician/Medical the Due to (or as a consequence or): resulting in death) Last USB 85 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No. 3 ☐ Probably 4 ☐ Unknown signed b of Vital Records, þ page 2 should 24b. Ware autopsy findings evallebie prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? peen certificate 1 Yes 2 No 1 Tyes 2 No. Be 25. Wes cese referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No al or Attending Physical Street death.

I Director: After this do in by the funeral d this 28a. Date of Injury (Month, Dey Year) 27. Mennar of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Division 1 Neturel 2 Accident 5 Pending investigation 1 TYes 2 TNo 3 Sulcide 6 Could not be 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide To the Hospital o within 24 hours af To the Funeral D completely filled I Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as steted.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and menner steted. Medical 29a, Certifier (Check only mudictor, M.O. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) JOHN nd eddress of person was completed ceuse of deeth (Item 23e) (Type, Print)

6 P8 Poole Road, Win John Middleton, M.D. Roge 31. Dete filad (Month 32. Registrar's Signature State Registrar



To the F within 2 5 State Registrar

31. Dete liled (Month, Dey, Year) DEC 2 3 1998

29b. Signeture end little of certifier

assen

HASSAN HODJATI

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32 Registrar's Signeture

7127 ALLETOWN RD

29c. License number

P0023387

29d. Date signed (Month, Day, Year)

12-20-98

CAMP SPRING

MD

20744

**DHMH 16 Rev 6/95** 

2001 8 S 330

hysician	1. Decedent's Neme (Fi	irst, Middle, La	st)			rtificat	0 01 1	000.		2. Dete of De	Reg. No.	Year	3. Time of Death
/Medical	MORRIS E.  4a Facility Name (If not			harl				th City To	wn orl	Decemb	er 19,		
aminer	5004 Lee J			1001)	Capitol Heigh					eights	Pri	eorge's	
ral or	5. Social Security Numb 578-94-027	70	ex ☑M 2☐ F	7. Age (In yrs. 36	lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of 8			8. Dete of Bir (Month, Da 9/29/	th ly, Year) 62		hplace (State or Foreign untry) Sh., D.C.		
tor	Usual Residence of Dec 10a. State 10t Md.	b. County P.G	•			Town or Location eenbelt						10d. Inside City Limits 1 □XYes 2 □ No	
Funeral Director	10e. Street and Number 7816 Hand		)4		10f. Zip Code 10g. Citizen of WI 20770 U.S.2						untry?		
by	11. Maritel Stetus  11 Never Married  3 Widowed 4	dent Ever in U, ces? 2½ No e tes:	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2★★No Specify:  14. Race - American India Black, White, etc.  Specify: Black							e, etc.			
eted	15. (Specify o	59 US	(Give	a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work one during most of working					Industry				
Be Completed	Elementery/Secondar 12th	4or 5+)							rivate Industry				
To Be C	17. Father's Name (First Morris S.			18. Mother's Neme (First, Middle, Maiden Sumame)  Margaret D. Nichols									
	19a. Informant's Name/ Margaret D.			r	1	ing Address				al Route Numb	er, City or To	own, State, 2	Zip Code)
	20a. Method of Dispositi 1 ☑ Burial 2 ☐ Cr 4 ☐ Donation 5 ☐	remation 3 [		C.	lace of Displemetery, cre	matory or o	ther place		n.   2	Date 2/26/98		ion - City or ton , Mc	
any injury	21. Signature of Funera	Il Service Licer	N. G	ratt	2	2.Name an H.S.W 4925	d Addre asni Bur	ss of Facili ngtor rough	ty 1 & S	Sons Co	.,Inc.	D.C	. 20019

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Part Be Completed by

4 Homicide

Due to (or as a consequence of):

Due to (or es a consequence of):

Ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use co	ntribute to the cause of death?
	1□ Yes ⊅XNo	3 Probably 4 Unknown
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 8 Nother (Specify) at Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of

5 Pending investigation 613 A 1 Naturel 12/19/98 1 Yes 2 2No 2 Accident subject Sho 6 Could not be determined 28f. Lot tion (Street and Number or Rural Routa Number, on or Town, Stele) 500 Y Lee Jey Dy Luc 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause's) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E. December 19, 1998

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1 BYes 2□ No

State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year)
DEC 2 4 1998

32. Registrar's Signeture



To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours effect death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

2EC 2 4 1930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Keating Kanmond 1. Decedant's Nama (First, Middle Last) 2. Dete of Death 3. Time of Death **Physician** December 25, 1998 William R. Keating 2.01 am /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lions Manor Nursing Home Cumberland Allegany 5. Social Sacurity Number If Under 24 Hrs. Hours Min. If Under 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Birthpiaca (Stata or Foreign Country)
 MD **Funeral** Year) 1928 Months Days 1X M 2□ F Director Yrs. Sep 10, 215-20-5309 70 Usuai Rasidance of Dacedant the Maryland Afform of the Highest and Marked other transport of the How marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Evansiser must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Allegany Cumberland MD 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 15604 Harvest Drive 21502 USA death Funeral permit. Pagas 1 and 2 should be filled within 72 hours after deat Department of Haalth and Merital Hygiena. Important: If frem 27 is marked other than any hijury or other trainment. 12. Wes Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Reca - Amarican Indian, Bieck, White, atc. 1 X Yes 2 □ No if Yas, Giva Year or Detes: WWII 1 Navar Married 2 Married 1 ☐ Yas 2X No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify white 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Educetion (Specify only highast grade complated) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Collega (1-4or 5+) Retired Safety Dept. Textile 12 17. Fethar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) Be William Keating 2 Lena (Hadley) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Delores Keating-wife 15604 Harvest Drive Cumberland MD 21502 20b. Piace of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Lutheran Cemetery Accident MD 12/28 21. Signatura of Funarai Servica Licenses 22. Nema and Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Pert1. Enter the disease, or complications that ceuse the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Deeth Physician /Medicai immediata Causa (Finai disaasa or condition rasulting in daath) rovercu an Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed for usa as the burial-transit Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Causa (Disaasa or injury that initiated evants resuiting in death) Last pug Due to (or as a cor P.O. Box 68760, physician Raw Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 ☐ Unknown witherth Division of Vital Records, Àq 24a. Was en eutopsy performed? Completed 24b. Wara autopsy findings available prior to completion of ceuse of death? peen this certificate has 1 Yas 2 No 1 Yas 2 No or Attending Physician: Be 25. Was cesa referred to medical 26. Placa of Death (Check only ona) To the Hospital or Attending Physic within 24 hours aftar death.

To the Funeral Director: After this completely filled in by the funeral dir Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 ☐ Yas 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturai 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicida Place of injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 I Homicide 29a. Certifian 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and piace, and due to tha causa(s) and mannar as stated.

2 Medicat Examinar: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, date and piace, end due to tha cause(s) and mannar stated. Medicai (Check only onel 29b. Signetura end title of certifian 29c. License number 29d. Dete signed (Month, Day, Year) Kan 10 who completed ceusa of daath (itam 23a) (Type, Print) 30. Nama and address of person V.A. Ranjithan ions Manor Nursing Home umberland Month, Day, Year) 32. Registrer's Signature State DEC

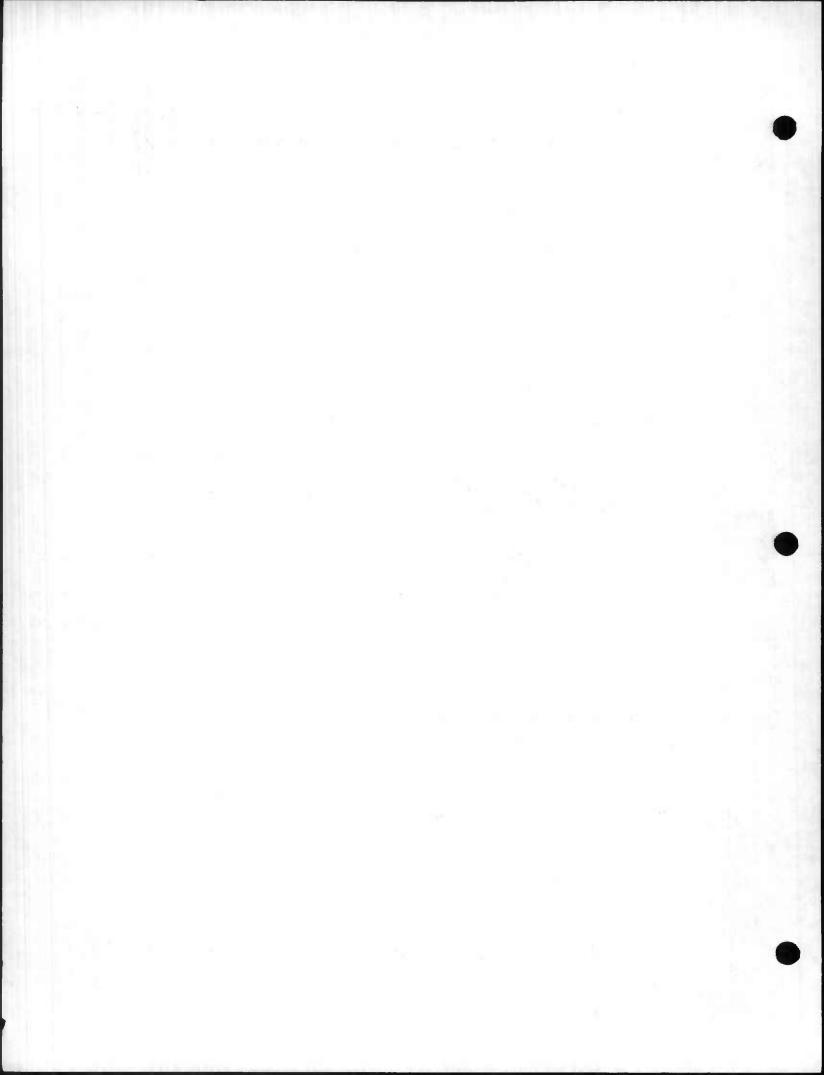
DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 🔾 Ethel Audrey King Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month HE 0600 )-20 /Medical 4b. City, Town, or Location of Deeth 4e. Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner HUNAPOLIS Arundel HOSP OEN. If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□ M 25 F 79 Director 218 74 3363 June 15, 1919 MD Usual Residence of Decedent the Mandend 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-fahow 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Examiner must be notified at MD Anne Arundel Crownsville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1520 Crownsville Road 21032-2399 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. should be filed within 72 hours after of Mentel Hygiene.

merked other than "natural", or ite 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) none none none 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic eve William Mary George Kina Matilda Armiger 10 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary A. Myers/niece 4580 FSK Highway, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Mt. Harmony UMC Cem. 12-17-98 Owings, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licens 22. Name and Address of Fecility Rausch Funeral Home, Owings, MD 23a. Pert1. Enter the disease, or complications that passed the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finei teriosclerotic Heart Disease disease or condition resulting in deeth) Examiner Due to (or es e consequence of): pertension burial-transit pue Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest physician s the burial Box 68760. MNK 1A befes Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. SchizoAffective Disordor, TArdive 1 Yas 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings evelleble prior to completion of cause of death? 24a. Wes en eutopsy performed? ISKINESIA, GLAUCOMA, GASTrifis certificate has 1 Yes 2 W6 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes cese referred to medicei exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ P/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Yes 2□ No 2 this funerai 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours effer death.
To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Neturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end menner stated. 29a, Certifier 29b. Signeture end title of certifier Deputy 29c. License number 29d. Date signed (Month, Day, Year) 06054 w use of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca America 2103 ones, MD 695 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



#### Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Dorothy May Logan Dec. 27, /Medical 4a. Facility Name (If not Institution, give street and number) ISAM 4b. City. Town, or Location of Death **Examiner** Homewood Nursing Center Williamsport 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours 1□M 2以F 215-50-5783 83 Yrs. Director Apr. 18, Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 27-98 7 is marked other than "natural", or hema 23a or 28a-f ahow traumatic event, the Medical Examener must be notified at Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 21740 1913 Maplewood Circle Funeral 5 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 → Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: þ 3 Widowed 4 Divorced A. Logan Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 2 should be find and Mental H Frank Royal Abbott 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: if item 27 Ia any injury or other trau Norman Leroy Logan, Sr./Husband 1913 Maplewood Circle, Hagerstown, Maryland 21740 Dorothy 20b. Piece of Disposition (Name of cemetery, crematory or other piace) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery-Dec.30,1998 Hagerstown, Maryland 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Douglas A. Fiery Funeral Home ese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, a. List only one cause as each line. 23a. Part1. El ter the disc shock, o heert illu **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner ATTIM physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as

23h. Did tohacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Were autopsy tindings evaileble prior to completion of cause of death?

Physician/Medical

þ

Completed

Certification: To

edicai

signed I

Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director; I

a Funeral

To the Hospi within 24 hours To the Funer completely fil

TUYES 2LINO

25. Was case referred to medical 1 Yes 2 Ne

31. Dete filed (Month, Dey, Year)

**DEC 28** 

27. Menner of Deeth

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

5 Pending investigation

8 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year)

28b. Time of

28e. Pieca of Injury - At home, ferm, street, tectory, offica building, etc. (Specify)

incern

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura

29c. License number

29d. Date signed (Month, Dey, Year)

n who can cleted cause of death (Item 23a) (Type, Print) NETZNON

Hospital:

32. Registrer's Signeture

State Registrar

**DHMH 16 Rev 6/95** 

Box 68760

P.O.

Records,

Division of Vital

3. Time of Death 8:15 AM

4c. County of Death Washington

1998

Birthpiece (State or Foreign Country)

Pennsylvania

10d. Inside City Limits 1 ☑ Yes 2 ☐ No

10g. Citizen of Whet Country?

USA

14. Rece - American Indian, Bleck, White, etc.

Specify: White

16b. Kind of Business/Industry

Own Residence

Hannah Elizabeth Winnemore

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

1331 Eastern Blvd.N., Hagerstown, Maryland 21742 Approximate Interval Betw Onset end De

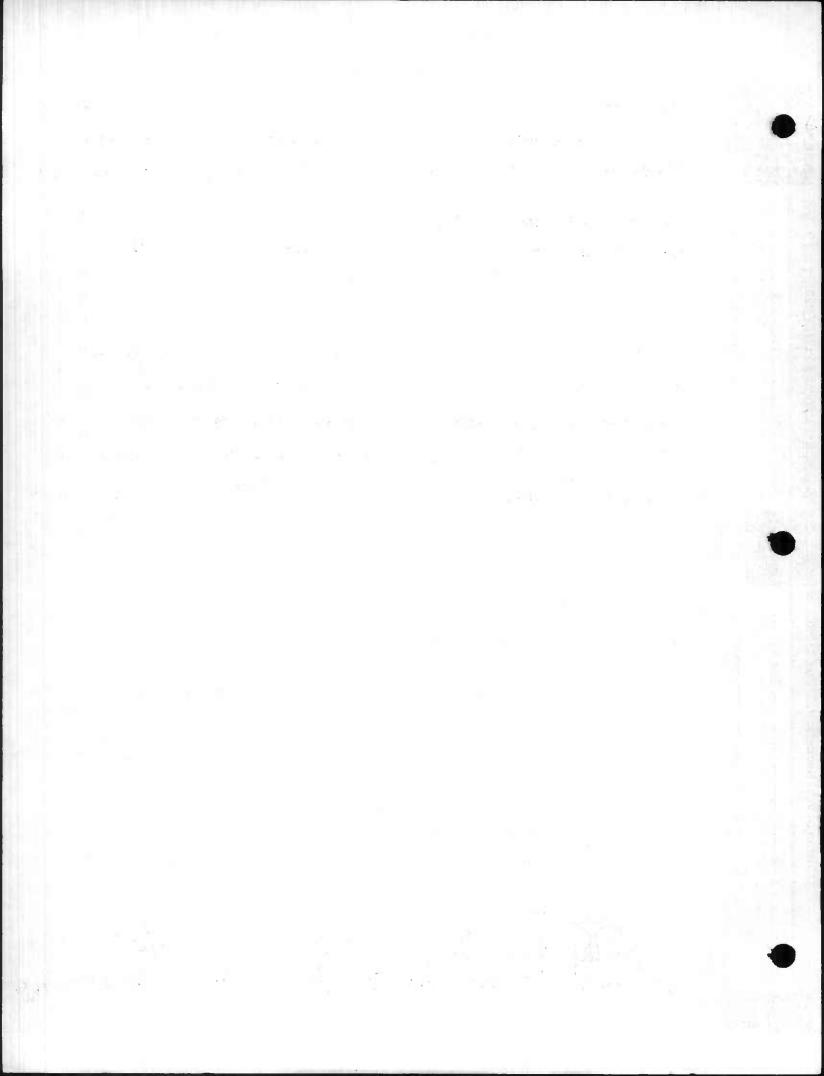
PALSSIUM

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t.

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (

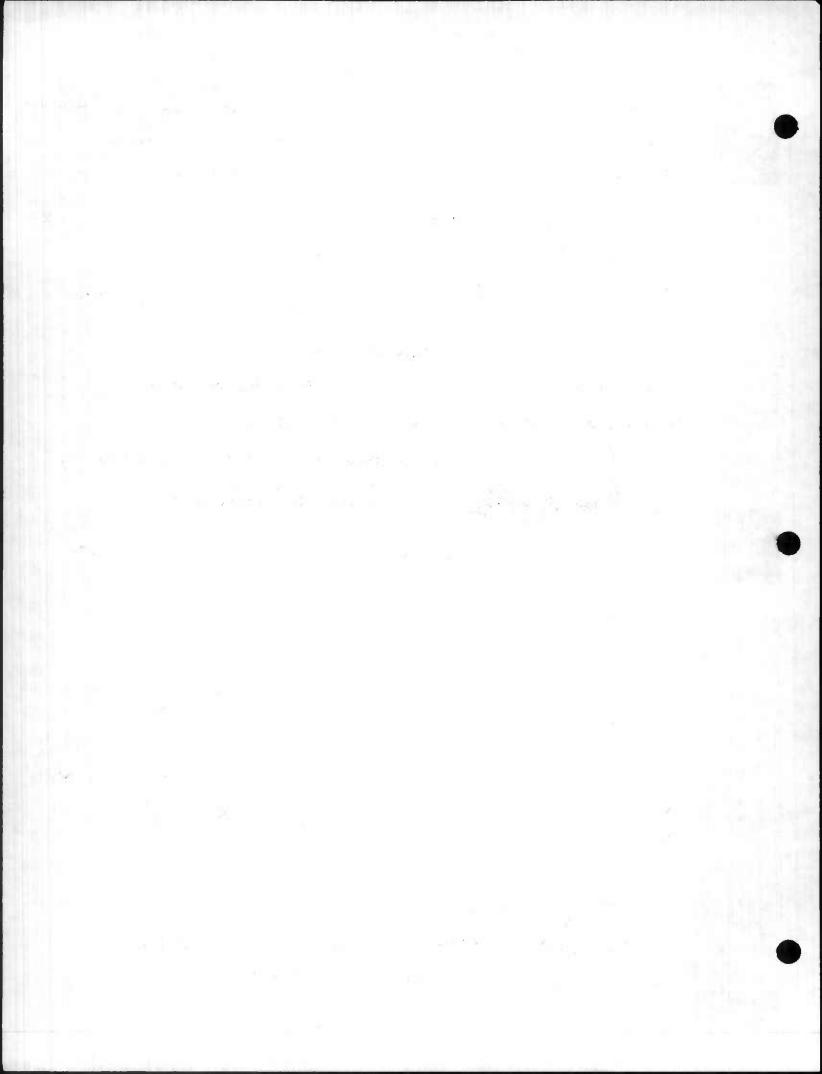
26. Place of Death (Check only one)

Other: 4 Norsing Home 5 Residence 6 Other (Specify)



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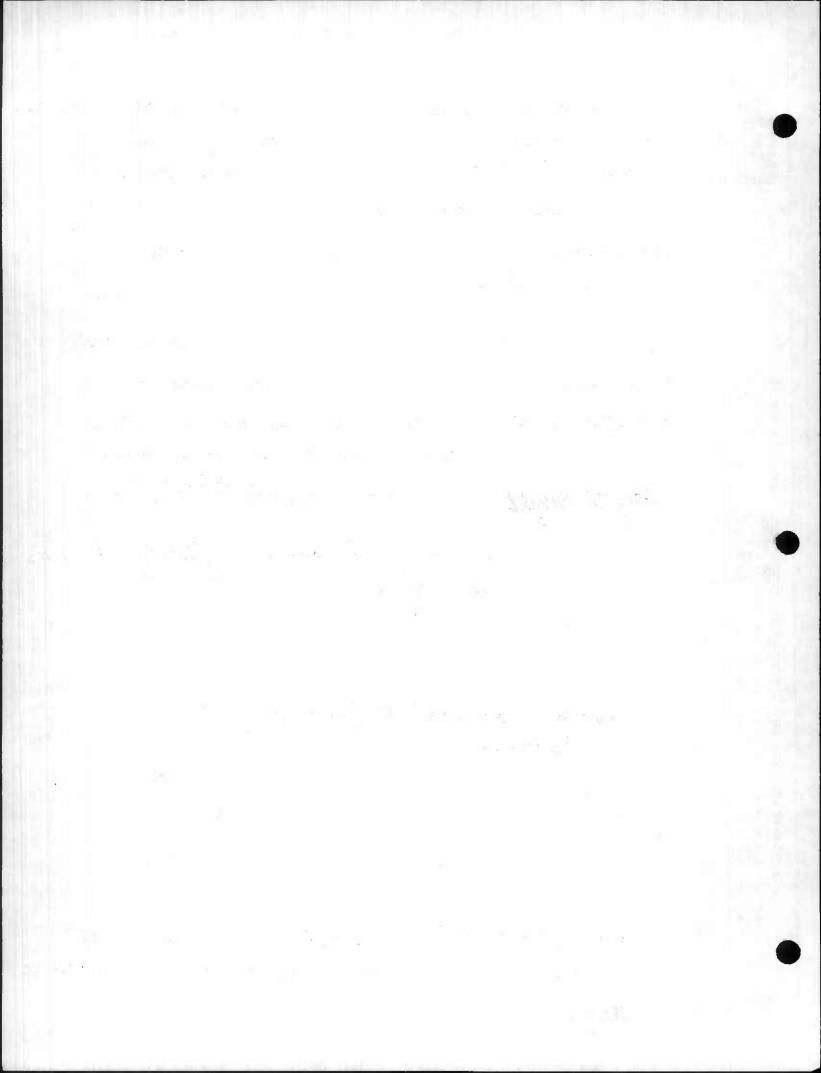
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Director		194-12-3	/ 51	_ M 2644F	80	Yrs.				9-25-	1918	0000	Panama
yland		Usuel Residence of 10a. State	10b. County		10c. Cit	y, Town or	Location					1	0d. inside City Limits
Mar	to	De.	Sussex		De:	lmar							1 ☐ Yes 2 No
A 284	Director	10e. Street end Nur	nber				10f. 2	ip Code			10g. Citizen o	f Whet Coun	ilry?
th wit	ai	Rt. 1 B	ox 489 P					199	40		USA		
filed within 72 hours effer death with the Maryland Hygiene. ther than "natural", or Heme 23a or 23e-f show ent, the Medical Examiner must be modified at	by Funeral	11. Marital Status  1 X Never Marri 3 Widowed	ed 2 Married	12. Wes Dec Armed Fo 1 Yes If Yes, Gi Yaer or D	2 XNo	,S. 13			lispanic Origin? ( an, Mexican, Pua Specify:	Specify Yas or Norto Rican, etc.)	o- 14. Ra Bi	ace - Americ eck, White, ify: Wh	
2 hou	be		15. Decedent's Ed	ucation		16e. Dec	edent's Us	uel Occur	pation		16b. Kind of	Business/Inc	dustry
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Peges nent of 1 int: If its iny or o			Cremation 3 1 5 Other (Specify)		State	mbrids				12-23-9	8 Cam	hrida	e, Md.
교투문문	Ιĵ		naral Service Licens		1				ss of Fecility	12 23 )	o cam	DILUG	e, ma.
Depared Park		Mari h	11. ( n.	1	///		Short	Fune	eral Home	-	100/	0	
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Examiner		disease or condition resulting in deeth)	1	е		r es e cons		η.					
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or Att efter d Direct J in by	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Plece buildi	of Injury - At he	ome, ferm, s	street, facto	ry, office	ice 28f. Location (Street end Number or Rural Routa Nu City or Town, State)				l Routa Number,
To the Hospital or Attency, within 24 hours effer deet To the Funeral Director: completely filled in by the		29a. Certifier (Check only	1 Certifying Phy	sician: To the	best of my kno	wledge, dee	th occurre	d et the tir	ne, dete end plec	e, end due to the	ceuse(s) end n	nsnner as st	eted.
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Physician   Mooting   Mo	
Madical Examiner   Astronometric   Astronome	e of Sweth
Tourish   Tour	50 A.M
S. Social Security Number   6. Sex   7. Age (in yrs. last birthday)   1 Under 1 Year   1 Un	
Usual Residence of Decedent   10c. Clay, Town or Location   Westminster   10d. Inside (	
10e. State   10b. County   10d. Inside (	ite or Foreign
Dewey Livesay    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	e City Limits
Dewey Livesay    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Dewey Livesay    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
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Dewey Livesay    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Dewey Livesay    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Physician /Medical Examiner  Physician /Medical Examiner  Haight Funeral Home & Chapel P.O.Box 195  Haight Funeral Home & Chapel P.O.Box 195  Approximately a considered the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and interval Be interval Be onset and interval Be onset a	
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Physician /Medical Examiner  Immediate Cause (Finel disease or condition resulting in death)  Immediate Cause (Finel disease or condition resulting in death)  Due to (or as a copsequence of):	
/Medical Examiner Immediate Cause (Finel disease or condition resulting in death)  a. Woodtate Cancus (Finel disease or condition resulting in death)  Due to (or as a copsequence of):	Between
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CINQUE Abstructive Duly 4000 1000 30 Probably 40	se of death?
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Si ta significant de la company de la compan	
So y serious y s	or to
	2 No
25. Was cese referred to medical examiner?	
0 5 5 5	
Second Process   Seco	
288. Place of Injury - At home, farm, street, factory, office  286. Describe now injury occurred  287. Location (Street and Number or Rural Route Nur  288. Place of Injury - At home, farm, street, factory, office  288. Describe now injury occurred  288. Describ	lumber,
4 Homicide building, efc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signeture and title of certifier (29b. Signeture and title of cert	se(s)
29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/23/98	7)
30. Name and address of person who completed cause of deeth (Item 23a) (Type-Print) Alle westwurster 4021	1157
State Registrar DEC 2 3 1998 32. Registrer's Signature 9. Sports	

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Day 18,1998 **Physician** 3:54 AM Anna Amelia Long /Medical 4b. City, Town, or Location of Death 4c. County of Death 4s Fecility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital 8. Dete of Birth (Month, Day, Year) Mar. 15, 1926 Birthplece (State or Foreign Country) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lesf birthday) If Under 1 Yaar **Funeral** Months 1□ M 229 F Deys 216-22-7967 72 Yrs. Maryland Director Ususi Residence of Deceden with the Meryland 10d. Inside City Limits 10a State 10c. City, Town or Location 10h. Counts 7 is marked other than "natural", or frams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Frederick Rocky Ridge Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21778 U.S.A. 10502-A Rocky Ridge Rd. by Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, atc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ther any injury or other transments. 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☼ Divorced Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Eiementery/Secondary (0-12) homemaker own home 10 18. Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middle, Last) Be Bessie Flohr Ezra Arbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 10502-A Rocky Ridge Rd., Rocky Ridge. MD 21778 Cheryl R. Long/ daughter 20b. Placa of Disposition (Nema of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/21/98 Union Bridge, MD Mountain View Cemetery 22. Name end Addrass of Fecility 21. Sign of Funeral Service Licensee Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway 10 23a. Part1. Enter the disease, or complications that caused the leath. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each im. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting In death) Examiner Due to (or as a consequence of) Examiner hysician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician that the death certificate be Physician/Medical Due to (or es e consequenca of) attending ed by the at detached fo 23b. Did tobacco use confribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part signed by t 1 Yee 2 No 3 Probably 4 Unknown à 24b. Ware sutopsy findings evailable prior to complation of causa of deeth? Completed 24a. Was en autopsy peed this certificate hes 1 □Yes 2□ No 1 Yes 2/2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 ☐ Yes 2 ☐ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death Date of Injury (Month, Day Year) 28c. Injury st Work? 28d. Dascribe how Injury occurred Certification: 28b. Time of 5 Pending Investigation Neturel 1 Yes 2 No 2 Accident 3 Sulcida 6 Could not be determined 28a. Pleca of Injury - At homa, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ HomicIde 29a. Certifian 1 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the tima, data and placa, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifie

State Registrar 31. Dete filed (Month, Dey, Year)
DEC 2 2 1998

MI MOCITE

32. Registrer's Signeture

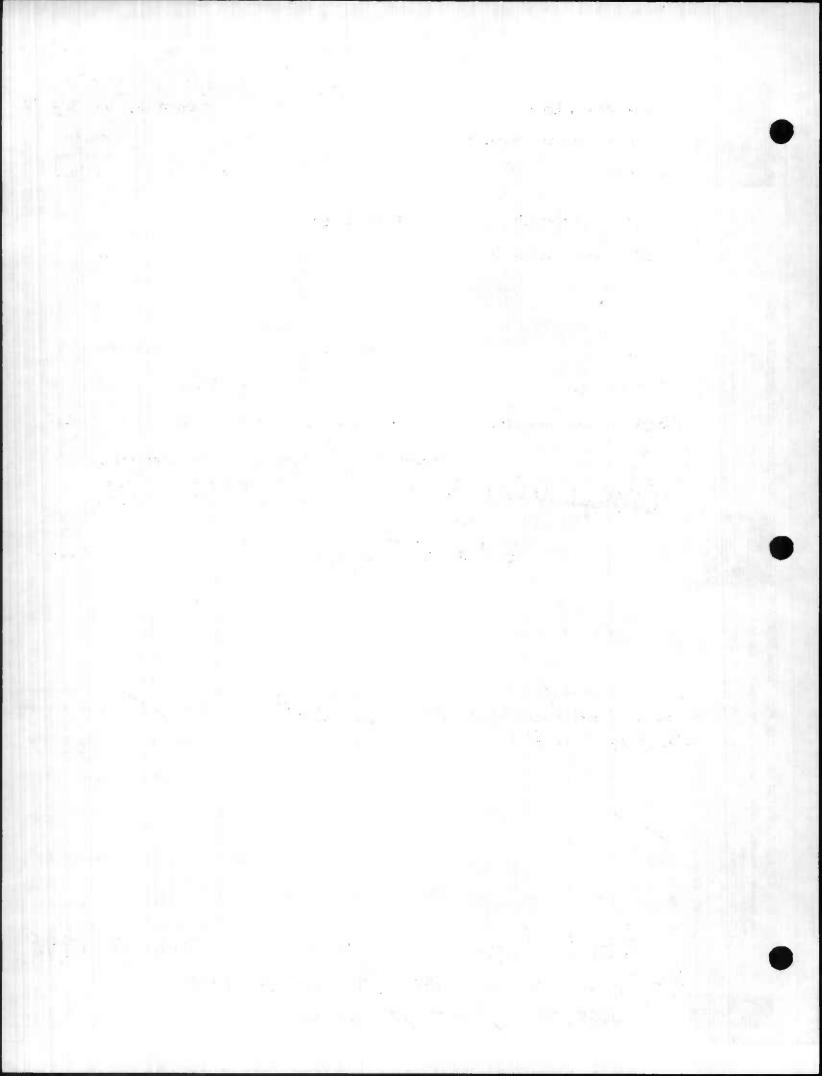
cause of deeth (Item 23a) (Type, Pri

G. Sparks

21702

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



		1. Decedent's Name	(First, Middle,	Last)		001	rtificate o		2	Date of Deat	eg. No. th		3. Time of Death	
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ral tor	1	5. Social Security Nu 234–38–8	8708	.Sex MM 2□ F	7. Age (In yrs	S. last birthday) Yrs.	If Under 1 Yes		24 Hrs. 8 Min.	Date of Birth (Month, Day, PR. 30, 1	Year) 928	9. Birthp Coun WEST	piace (State or Foreigntry) VIRGINIA	
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	ב	10e. Street end Num					10f. Zip Code			10		Citizen of What Country?		
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i want	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  (Give kind of work done during most life. DO NOT use retired)  SERVICE REPRESEI						1)			PETROLEUM CO. SOUTHERN STATE			
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-		19a. Informant's Nar HELEN			E		g Address (Stre					State, Zip		
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		21. Signature of Funeral Service Licensee  **DEAD P. Lip Church**  23a. Part1. Enter the disease, or complications that caused the deeth.					Name and Add PCHURC	H FUNI	ERAL			267		
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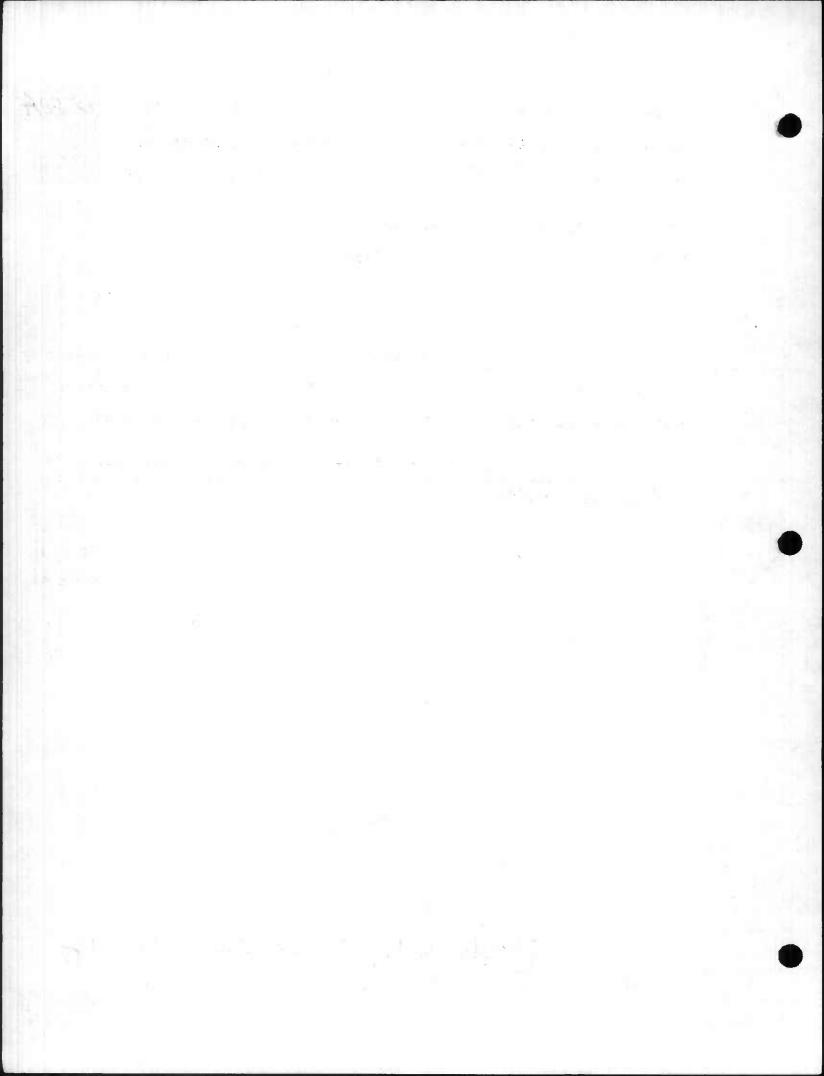
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Sand W. Lastones.

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State of Maryland / Department of Health and Mental Hygiene 98 4 53

					Certificate of	r Death	B	leg. No.	
		1. Decedant's Name (First, Middla, La	st)				2. Date of Dear	th	3. Time of Death
Physician Medical/		Evelyn M. Loc	hner				Month 12	Day 21 19	Year 98 12:20
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uneral	5	5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birt		er   ff Undar 24 Hrs.	8. Data of Birth		Birthplaca (State or Fore Country)
irector		216-22-5240  Jsuel Rasidance of Dacedent	□M 2)(1 F 8 5	5	rrs. Months De	ys Hours Min.	9-27-1	3	W V
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or 28a4 e		0e. Street and Number			10f. Zip Code	a	- 1	0g. Citizen of W	het Country?
23a c		25701 Shady La	ne SW		21562	2		US	
ritems 234		1. Maritel Status	12. Wes Dacedent E Armed Forces?	ver in U,S.	13. Was Decedant of	of Hispenic Origin? (Spuben, Maxican, Puarto	ecify Yas or No-		- Amarican Indian,
0 5		1 Nevar Married 2 Merried 3 Widowed 4 Divorced	1 Yas 2 XN If Yas, Giva Year or Datas:	0	1 □ Yas 2 ☒ N		riicari, etc./		White White
	3	15. Decedent's Ed	lucation	16a.	Decedent's Usual Occ	cupation		16b. Kind of Bus	sinass/Industry
		(Specify only highast gra	College (1-4or 5-	+)	(Giva kind of work doi life. DO NOT usa ret	ne auring most or won ired)	ang		
ther than		8.			rsing Ass	sistant		Hospit	al/Nursing
5 5 0		7. Father's Nama (First, Middle, Last)	)			18. Mothar's Nam	a (First, Middle, I	Ma <i>idan Sumam</i> e	1)
		John Cheshire				Elise (	Riggle	man) C	heshire
7 is marke traumatic To		19a. Informant's Name/Relationship (			Mailing Addrass (Stre				
127 er tr		Betty Bane/Dau	ghter	3	West Fre	ederick S	treet	Piedmo	nt WV 26750
r other	2	0a. Method of Disposition	Demonstra	20b. Place of cematary	Disposition (Nama of y, cramatory or other p	place)	Data	20c. Location - (	City or Town, State
nt: H		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )		Phil:	os Cemete	erv 1	2-23-9	8 West	ernport MD
Important: If any injury or once.	1	21. Signature of Funerel Sarvice Licer	ISBB //	10	22. Name end Add	drass of Facility Fr			
E 2 8	ŀ	1. las HX	11/1/10/	LI	PO Box	4 31 Jon	es Str	eet Pi	edmont WV
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he Funerel Director: After this certific pletely filled in by the funeral director, edical Certification: To Be	2	1  Yas 2  No  7. Manner of Death 1  Actives 2  Accident 3  Suicide 4  Homicide  29a. Cartifier (Check only one)  1  Certifying Phyone)	28a. Data of Injun (Month, Day) 28a. Place of Injun building, atc.	ry - At home, fer (Specify) I my knowledge, axamination and	M 1 m, straat, fectory, office daath occurred at the l/or invastigation, in m	tima, data and placa, y opinion, daath occur	City or Town	ause(s) and mar ata and place, a	nner as steted. nd dua to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) **Physician** Christina May Llewellyn December 24, 1998 5:45 p.m. /Medical 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Memorial Hospital & Medical Center Cumberland Allegany If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthplace (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) Funeral Days Hours 1 M 200 F Yrs. 219-74-9930 MD Director April 11,1926 Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 23s-f show should highly or other traumatic system, I'm Modest Exerting must be notified at 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic avent, the Medical Examiner must be noutled at 1 ☐ Yas 2 No Directo MD Allegany Cumberland 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21502 USA Furnace Street Extended Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married specify: White 1 ☐ Yas 2 ☑ No by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker Home 0 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Sophia Elizabeth Moreland John Russell Llewellyn 19a. Informant'a Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) James Llewellyn Brother 1634 Morning Dove Loop North, Lakeland, FL 33809 20a. Mathod of Disposition 20b. Piece of Disposition (Nama of cematary, cramatory or othar place) 20c. Location - City or Town, Stata Dec. 28 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Moscow Mills, MD 4 ☐ Donation 5 ☐ Othar (Specify) 1998 Laurel Hill Cemetery 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Pu/ Eichhorn-McKenzie Funeral Home P.A. ames & McKenzie 23a. Partt. Entar tha disaasa, or complications that ceused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest,

A. 21539

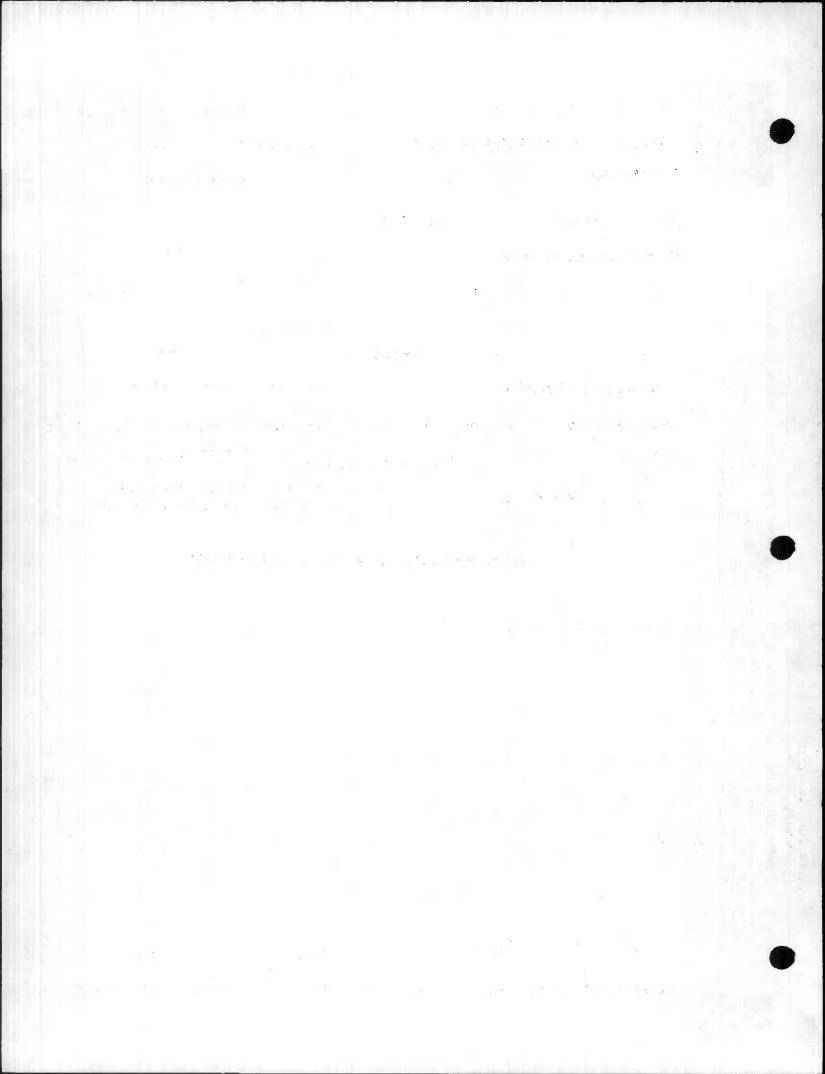
23a. Partt. Entar tha disaasa, or complications that ceused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest,

A. 21539 Approximate Interval Batween Onset and Death Physician Immediata Causa (Fine) disaasa or condition resulting in death) /Medical a Acute myocardial infarction, anterior wall 3 days Examiner Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Causa (Disaasa or Injury that Initiated evants Due to (or as e consequence of) P.O. Box 68760 Dua to (or as a consequence of) rasulting in death) Last been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b, Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed performadi 1 Yes 2 No 1 Yes 2040 certificate Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 213-09-9871 1 Yes 2 No 1⊠npatient 2□ER/Outpatient 3□ DOA Certification: To After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 SNatural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No death. 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 T Homicide within 24 hours a To the Funeral [ ✓ Centrying Physician. To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 25 Joanne D 14865 Colley 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) M.D., Memorial Hospital Medical Building, Cumberland, MD 21502 Robustiano Barrera, 31. Data filed (Month, Day, Yaar) DEC 2 9 1998 32. Registrar's Signature State Registrar

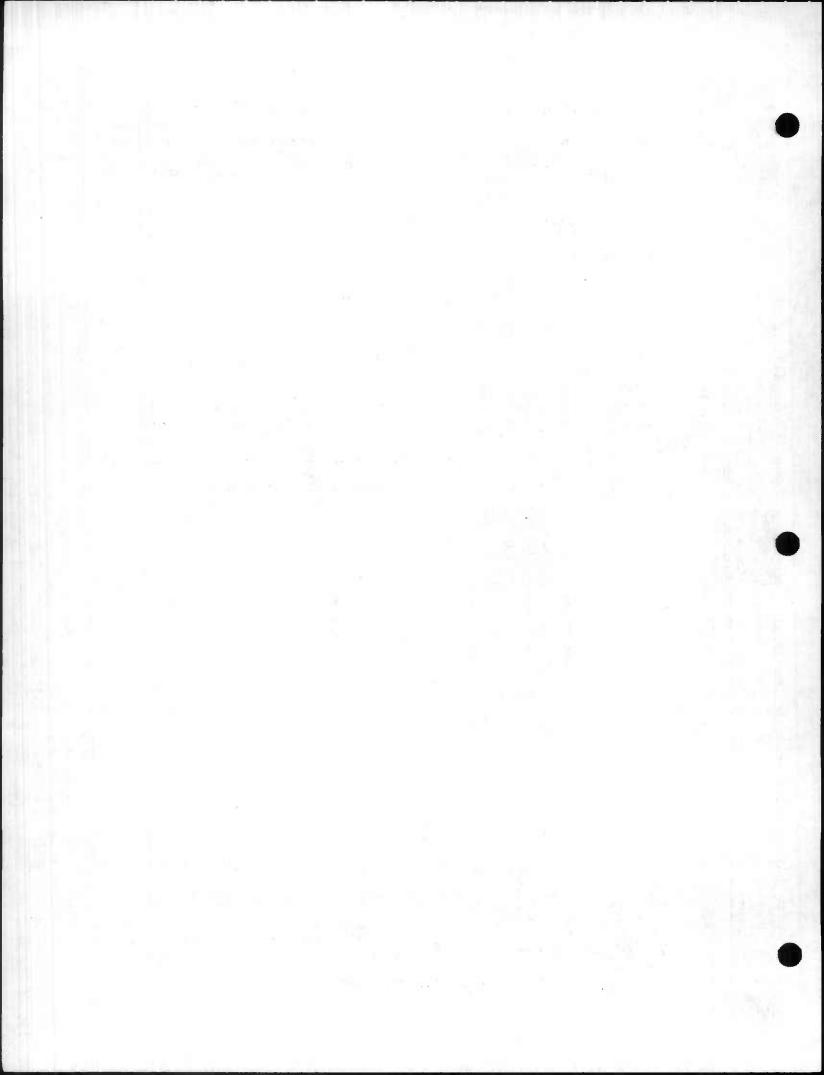
DHMH 16 Rev 6/95

Christina Llewellyn



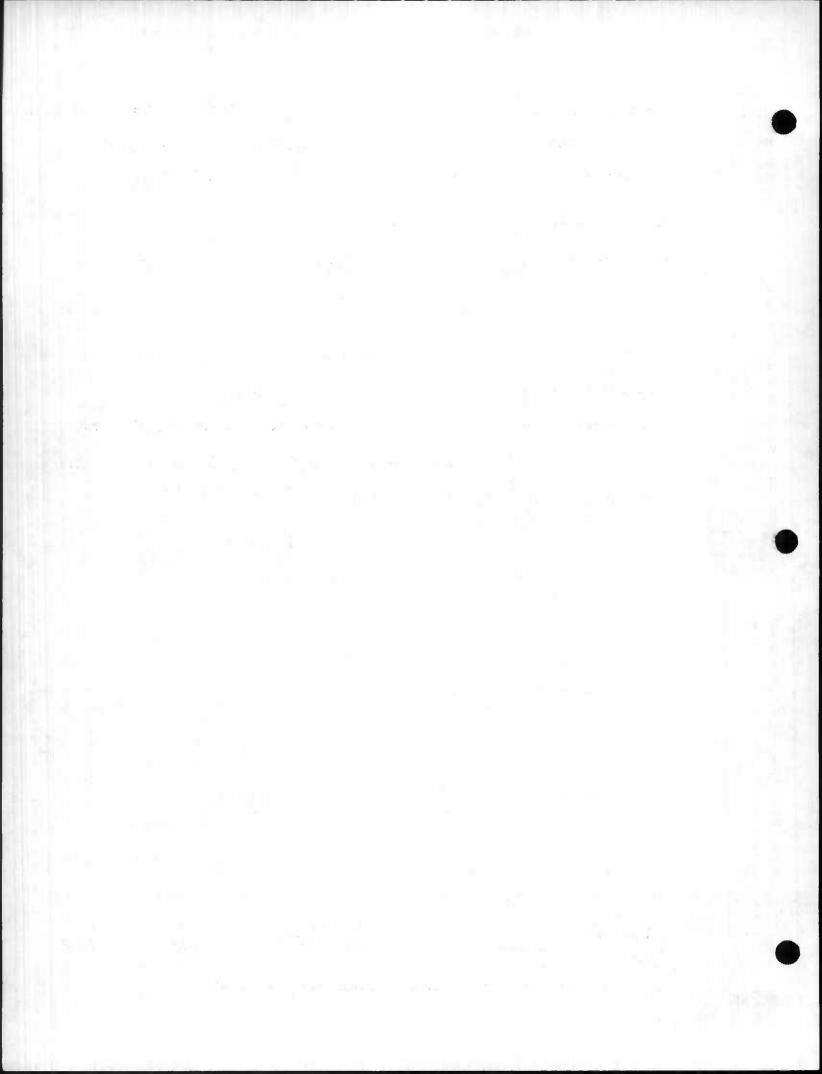
State of Maryland / Department of Health and Mental Hygiene

o volo		1. Decedant's Neme (First, Middle, Las	t)		7.1			2. Date of De		Vace	3. Tima of Death		
nysici Media		PAUL VINCENT	EPLEY					Dec 2	6, <sup>1</sup> 998	Yaar	9:45 pm		
xamir		4a. Facility Nama (If not Institution, give	street end nu	im <i>ber)</i>			4b. City, Town, o	r Location of Deet	eeth 4c. County of Death				
		213 OAK STREET					CUMBERI		ALLE	GANY			
ral tor		5. Social Security Number 6. S. 213-24-6481  Usual Rasidanca of Dacadent	ax XM 2□F	7. Aga (In yr.	s. last birthday) Yrs.	If Un r 1 Y Months Day		s. 8. Date of Bir (Month, Di NOV	1929	9. Birthp Caug	laca (Stata or Fore		
		10a. Steta 10b. County		10c. C	City, Town or Lo	cation				10	0d. Insida City Lim		
	tor	MD Allegan	7		Cumbe:	rland					1 XYes 2		
	Director	10e. Street and Number				10f. Zip Coda			10g. Citizen of 1	What Coun	try?		
	alc	213 Oak Street				215	02		US	SA			
	by Funeral	11. Merital Stetus  1 □ Nevar Married 2 Married  3 □ Widowed 4 □ Divorcad	1 XYes If Yas, Gi	va		Was Dacedant of f Yes, specify Cu 1 ☐ Yes 2 No.	Hispenic Origin? (ban, Maxican, Pue	Specify Yes or Norto Rican, atc.)	o- 14. Red Blac Specifi	ce - Amarico ck, White, o			
	B	15. Dacadant's Ed		etas: Kor		tant's Usual Occ	Insting		16b. Kind of B				
	Completed	(Specify only highast grad	la completed)		(Giva	kind of work don DO NOT use ratir	Occupation dona during most of working ratired)		TOD. KING OF B	asinasanii	Industry		
	E O	Elementery/Secondary (0-12)	Collega (	1-40r 5+)	Ret.	Bus Driv	er er		Bus C	ompan	y		
11	Be C	17. Fether'e Nema (First, Middle, Last)					18. Mothar's No	ama (First, Middla	, Maidan Suman	10)			
	ToE	Rister Lepley					Sarah	(Lewis)					
		19a. Informant's Name/Relationship (7					et and Number or F			State, Zip	Coda)		
		Dolores J. Leple	ywif				eet; Cumb	perland,	MD 215	02			
		20a. Method of Disposition  1 Surial 2 Cremation 3	Removal from			sition (Name of natory or other pi		Dete	20c. Location -	City or To	wn, Stata		
		4 ☐ Donation 5 ☐ Other (Specify	)	S		's Luth		12/29	Cumbe:	rland	, MD		
Duck		21. Signature of Funarai Sarvice Licens	1. 10	0100	W 22		ress of Facility Ili Fune: land, MD		, P.A.				
		23e. Part1. Enter the disaese, or comp shock, or haart tailure. List only	ilcations that one cause on a	aused the dae	eth. Do not ente	er the moda ol dy	ring, such es cardie	ac or raspiratory a	arrest,		Approximata intervai Between		
n il r		immadiata Cause (Final disaasa or condition				c Heart					Onset end Deeth Uk yrs.		
-	Iner	rasulting in deeth)	Ну	Dua to	or as a consequidemia	uance ot):					Uk yrs.		
	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0.	Due to	(or as a conseq	uence of):							
	Medical	resulting in death) Last	d	Due to (	or as a conseq	uence of):				1			
1	lan		u.										
	Physician/N	Pert II. Other significant conditions co	ntributing to de	eath but not ra	sulting In tha ur	ndarlying cause g	ivan in Part I.	23b. Did	tobacco use co	ntribute to	the cause of dear		
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	Completed by								en autopsy ormed?	eva	re autopsy linding illable prior to npletion of cause		
1	E C								- 10		leeth?		
		25 Was onen intered to medical						10	/0	1	Yas 2□ No		
	o Be	25. Was case ratarred to medical examiner?  Yas 2□ No	fospital:		Troje		hor	eath (Check only o					
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	를	Natural 5 Pending Invastigation	(Mon	th, Day Year)	Injury		ork? ]Yas 2∐No						
	Certification:	3 Suicida 8 Could not be 4 Homicida datarmined	28e. Place building	of Injury - At I	noma, larm, stre	eat, factory, office		28l. Location (Street and Number or Rural Route Num City or Town, State)			Route Number,		
	edical (	29a. Certifiar (Check only one) 1 Certifying Phy	ner: On the ba	best of my knows is soft examination of examinations of examinations of examinations of the state of the stat	owledge, daeth ation and/or inv	occurred at tha t astigation, in my	ima, date and plac opinion, daath occ	e, and due to the surred at tha tima,	causa(s) and ma date and piece,	innar as sta and dua to	ated. the ceuse(s)		
	2	29b. Signature end titia of cartified	1/				sa number		29d. Dete signer	d (Month, E	Day, Year)		
		Mills et	~			100	2915		Den 2	7.199	19		
		30. Name and address of person who co	mplated caus	a of death (Ita	m 23a) (Type, f	Print)				1000			
2		Dr. Paul Snow;											



State of Maryland / Department of Health and Mental Hygiene

					Cer	rtificate d	of Death		Reg. No.		
Physic		1. Decedant's Neme (First, Midd			1.81		EAST .	2. Data of Da Month	Day	Year	3. Time of Deeth
/Med Exami		Anthony J.  4e. Facility Nema (If not institution	n, giva street end nur	nber)				or Location of Deel		y of Death	11:11 am
Funeral Director		Memorial Hos 5. Social Security Number 214-07-6936 Usual Rasidence of Decedent	PITAL 8. Sex 1∏ M 2□ F	7. Age (In yrs. 83	last birthday) Yrs.	If Undar 1 Ye Months Da		n. 8. Data of Bi	rth	9. Birthol Count IN	aca (Stata or Foraig try)
the Maryland 28a-f show notified at	٥٠	10a. Stata 10b. County		10c. Ci	ity, Town or Lo				7	10	od. Inside City Limits
72 hours efter death with the Maryland natural; or items 23s or 28s-f show occal Every occurs to nutried at	rai Director	MD Alleg 10e. Street end Number 1315 Michigan			Cumber	10f. Zip Cod			10g. Citizan of		Λ
urs efter dea af', or items	by Funeral	11. Marital Status  1 □ Navar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Fo	2 □ No e	1		of Hispanic Origin? Juban, Mexican, Pu	(Specify Yas or No arto Rican, etc.)	Specif	-	etc.
d within giene. or than	Completed	(Specify only higha Elamentery/Secondary (0-12)	Collaga (1		16a. Decad (Giva lifa. L	lant's Usual Oc kind of work do DO NOT usa rei	na during most of w ired) g Dept.		16b. Kind of B	usinass/ind	vhite ustry
should be nd Mental marked o	To Be	17. Fethar'a Name (First, Middle, Orizo Lagrat 19a. Informant's Name/Relations	ta		19b. Mailin	g Addrass (Str	Lena and Number or				Coda)
of Heal		Ella M. Lagra  20a. Method of Disposition  1	3 □Removal from S	State	Place of Dispos cematary, cram	Michig sition (Nama of natory or other)	olace)	Data	20c. Location	- City or Tox	wn, Stete
permit. Peges Department of Important: If it any injury or o		21. Signature of Funaral Service	Licenspe	auge	M - 22.	Nama and Ad Scarpe Cumber	dress of Facility elli Fune: cland. MD	21502		ciano,	, MID
Physician /Medical Examiner	er	23a. Part1. Enter the diseasa, or shock, or heart teilura. List Immediate Causa (Final diseasa or condition resulting in death)		eriosc		: Heart	Disease	ac or raspiretory a	rrest,		Approximete Interval Between Onset and Death  UK YTS
rtificete be executed ng physician and es the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		or as a consequ					1	
requires that the deeth cert een signed by the ettendin hould be deteched for use	by Physician/M	Part II. Other significant condition	d	ath but not ras	uiting in tha un	dariying causa	given in Pert I.		tobacco uss co Yss 2□ No	ntributs to	the cause of death
2 S S	Completed t							perfo	an autopsy ormed?	com of d	re autopsy tindings liabla prior to plation of cause eath?
sician: The certificate irector, pag	Be	25. Was casa refarrad to medical axaminar?  Yas 2 No	Hospitel:				Whor	eath (Check only o	ona)		Yas 2□No
To the Hospital or Attending Physician: The i within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	27. Menper of Death DS Natural 2 Accident 3 Sulcide 4 Homicida	28a. Data o (Monti	f Injury o, Day Year)	ER/Outpatient 28b. Tima of Injury oma, farm, atre y)	28c. In	jury at /ork?	g Homa 5  Rasidance 6 Othar (Sp 28d. Describe how Injury occurred  28f. Location (Street end Number or F City or Town, State)		red	
the Hospital hin 24 hours of the Funeral I	edicai	one) Medicai I	Physician: To the backaminer: On the backaminer:	sis of examine	wledga, daath tion and/or Inve	occurred at the estigation, in m	time, deta and piac y opinion, daath occ	ce, and due to the curred at the time,	causa(s) and ma data and place,	annar as sta and due to	ited. the cause(s)
To the within To the comple	W	29b. Signature and titla by certifier		of death the	000) (7.	Do	957		29d. Deta signe Dec 7		
nes	te	Dr. Paul Snow 31. Data tiled (Month, Day, Year)	7; 124 W.		Street;		cland, MD	21502			



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death Dec 23, 1998 Glenn E. Landis 2:30 am 4a. Facility Name (If not Institution, giva streat and number) 4b. City, Town, or Location of Desth 4c. County of Death 648 Baker Street Cumberland Allegany 5. Social Security Number 6. Sex. 18 M 2□ F If Under 1 Yasr If Undar 24 Hrs. Data of Birth (Month, Day, Year) 1929 Feb 20, 1929 Birthplaca (Stata or Foreign County) PA 7. Aga (In yrs. last birthday) Days 220-28-9922 69 Yrs. Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 648 Baker Street 21502 USA 12. Was Dacedant Evar In U.S. Armed Forcas? 1 ∰Yes 2 □ No If Yes, Give Yaar or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) Rsce - Amarican Indian, Black, White, etc. 11. Maritai Status 1 Navar Marriad 2 Msrried 1 Yas 2 No 3 ☐ Widowed 4 ☐ Divorced Specify white 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Retired Cook Food Service 17. Fathar's Name (First, Middla, Last) 18. Mother'a Name (First, Middle, Malden Sumama) Emmons William Landis Zella A. (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby M. Landis-wife 648 Baker Street Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stats 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 12/26 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Part 7. Enter the disease, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respirstory srrest, shock, or heart failura. List only one cause on deach line. Approximate tntervsi Between Onset and Death Immadiate Cause (Final disaase or condition resulting in death) Que to (or as a consequence of): 8 Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated events rasuiting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an sutopsy performed? TUYES ZUNO 25. Was case referred to medical 26. Place of Death (Check only one) No No Othar: 4□ Nursing Hom Rasidence 6 □Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiena.
Important: If item 27 is marked other than "natural" ---any injury or other traumetic avairable.

Hospital or Attending Physician: The law requires that the death certificate be executed buriel-transit and Division of Vital Records, P.O. Box 68760, ate has been signed by the ettending physician page 2 should be detached for use as the burie certificate efter death. Director: After this filled in by the funeral

Physician/Medical

þ

Be Completed

2

edical Certification:

3

within 24 hours e To the Funeral D completely filled 3

To the

30. Name and address of person

27. Manner of Death

Natural 2 Accident

29a. Certifier

3 Suicide

4 Homicide

29b. Signatura and title of certifier

W. Guy Fis 31. Data filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be determined



28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At homa, farm, street, factory, office building, etc. (Specify)

cause of death (Item 23a) (Type, Print)

Avenue; Cumberland, MD

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(a) and manner es ststed.

Medical Examiner: The basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. Licanse number

➤ D12779

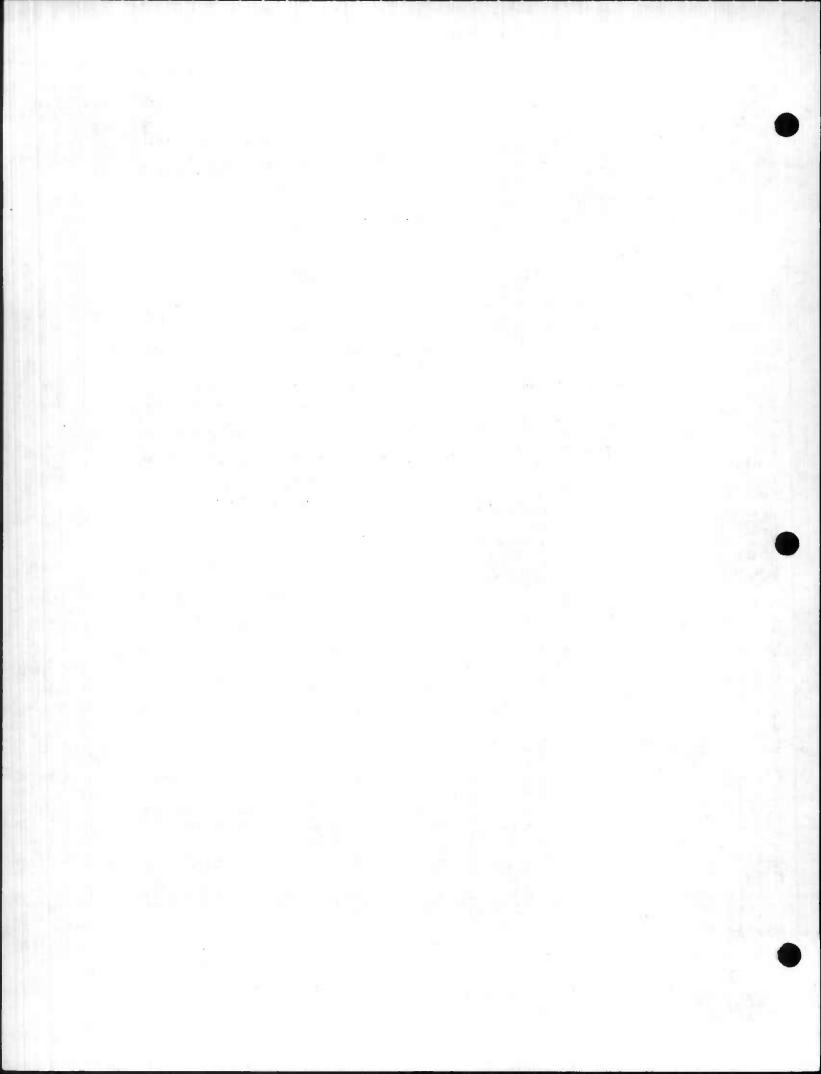
1 Yes 2 No

28d. Deacribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

State DEC 2 3 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

98-7280-025 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Day **Physician** MEI **GUAN** 12, 1998 DEC. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD Examiner BEL AIR ROCK SPRING ROAD If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1MM 2□ F 510-951-346 61 NOV. 19,1937 CHINA Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits

**Funeral** Director

Director

Funeral

Py

Completed

8

the Manyland ahow r than "natural", or hams 23a or 28a-f ahor the Medical Examiner must be notified at death filed within 72 hours after Hyglene.

permit. Pages 1 and 2 ahould be file Department of Health and Mental Hy Important: If flem 27 is marked othe eny injury or other treumatic event price.

21215-0020

Saltimore, Maryland

Physician /Medical Examiner

attending physician and for use as the burlef-transit the death certificate be assouted The law requires thet algned t page 2 certificate or Attending Physician: director, this funeral After deeth. after death Director: 2 filled in To the Hospital of within 24 hours at To the Funeral D completely filled it

68760 Box P.O. Records, of Vital 8 Certification: To Division edical

21. Signatu Examiner Physician/Medical P Completed 25. Was case referred to medical

tight Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Cylifical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

No 2 No

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

1 Natural

MARGORAD 31. Date filed (Month, Day, Year)
DEC 2 1.1998

em 32. Pegistrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

RODOWS

28a. Date of Injury (Month, Day Year)

1298

28b. Time of Injury

2254P M

11:45 PM Birthplace (State or Foreign Country) CANADA 1 Yes 2 No AGIN COURT, ONTARIO N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 KING LOUIS CRES. M1T2W8 N/A 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 No Specify: Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHEF 12 RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JIAN YUN ZHANG 2 KING LOUIS CRES. AGIN COURT, ONTARIO M1T2W8 CANADA WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HOLLYWOOD MEMORIAL PARK 12/29/98 UNION, NEW JERSEY 4 Donation 5 Other (Specify) o of Funeral Service Licenses 22. Neme end Address of Fecility P.O. BOX 26528 CENTRAL VIRGINIA FUNERAL SERVICE RICHMOND, VA se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE DA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? TUPSON 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence Other (Specify) AT SCENE

28. Place of Death (Check only one)

28d. Describe how injury occurred PEDESTRIAN STRUCK BY CAR

281. Location (Street and Number or Rural Routa Number, City or Town, State) Coak Spring RD. HARRONDGO HM

> 29d. Date signed (Month, Day, Year) DEC. 13, 1998

28c. Injury at Work?

29c. License number

O.C.M.E

1 Yes 2 No

State Registrar

months to

de9:13:036

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death Month 8:50 pm James Jackson Little 12-16-98 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Prince George's Comm. Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (in yrs. last birthday) Birthpiaca (Stata or Foreign Country) 1XM 2□ F Yrs. 244-40-3147 8-14-30 North Carolina 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 Larchmont Avenue 20743 IISA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. TY Yes 2 No If Yes, Giva Yaar or Datas: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 1953 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11th Procurement Officer Dept. of Navy 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Jack Mays Louise Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 617 Larchmont Ave., Capt., Hgts., Md. 20743 ace of Disposition (Name of Date 20c. Location - City or Town, State Geneva Little, Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition K Buriat 2 Cremation 3 Removal from Stata Maryland Vet. Cem. 12-23-98 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ralph Williams Funeral Service 21. Signat e of Funarai Service Licensee 517 11th St., SE, Wash., DC 20003 2 a. Pert I. Enter use disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in feilure. List only one cause on each line. Approximate Interval Between Onsat and Death tmmediata Causa (Final disease or condition rasulting In death) a Coronary Artery Disease Year Due to (or as a consequence of): Diabetes Mellitus Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequance of): Hypertensive Cardiovascular Disease Year Dua to (or as a consequanca of) Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Û Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes XCXNo 1 ☐ Yes 2 ☐ No 28. Place of Death Check only onal Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 5 Pending Invastigation 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Funeral

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Completed

Be

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show treumatic svent, the Medical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after to be partment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or ites eny injury or other treumatic event, the Medical Examinate Botte.

Baltimore, Maryland 21215-0020

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certificate be executed physician end s the buriel-trens 80 950 ed by the e signed by t peen has certificata funeral director,

this

After

ofter death.

within 24 hours To the Funeral completely filled

Box 68760

Division of Vital

Examiner Physician/Medical þ Completed Be 2 Certification:

25. Was case referred to medical

1 Yes 2 No 27. Mannar of Death

Natural 2 Accidant 6 Could not be determined 3 Suicide 4 Homicide

Cusar

DEC 2 1 1998

29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. (Check only one)

2 Medical Exeminer: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of cartifier Soliano

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Spacify)

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) Cesar Soriano Jr., MD

20743 119 Capital Hgts. Blvd., Capital Hgts., Md.

Registrar

Medical

31. Date filed (Month, Day, Year)



**DHMH 16 Rev 6/95** 

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		Ce	ertificate of	Death	Reg	J. No.	0		
1. Decedent's Nama (First, Middl	a, Last)				2. Data of Death	_	Maria	3. Tima of De	eath
Odell Leonard					Month Decembe:	r 19,	1998	12:48	P.M.
4a Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or I	ocation of Death	4c. Count	y of Death		
Prince George	's Hospit	tal Center		Cheverly	7	Prin	ice Ge	eorge's	
5. Social Security Number	6. Sex 1☑ M 2□ F	7. Age (In yrs. last birthday	If Under 1 Yea   Months   Deys		8. Date of Birth (Month, Day,	rear)	9. Birthpl Coun	lace (Stata or F try)	oreign

**Funeral** Director

**Physician** 

/Medical

Examiner

the Maryland ahow r than "natural", or items 23s or 28s-f ahov the Medical Examiner must be notified at death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic avant, the Medical Essentiant and Books.

Baltlmore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Box 68760. 2 0 P.O. signed by the Records. page 2 1 Division of Vital or Attending Physician: this funeral After 3

Examine Physician/Medical P Completed Be edical Certification: To hours after death. To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

Prince George 5. Social Security Number 250-02-0658 April 28, 1954 |South Carolina Usuel Rasidence of Decedent 10a Stata 10b. County 10d. Inside City Limits 10c. City. Town or Location Yas 2 No Director Maryland Prince George's North Brentwood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4606 40th Street U.S.A. 20702 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: African-1 Never Married 2 Merried 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Private Industry 10 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) 8 Frazier Brown Maybelle Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Leonard - Spouse 4606 40th Street, North Brentwood, Maryland 20702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Guilford Memorial Park 12/23/98 Greenboro, NC 22. Nama and Addrass of Facility
Gasch's Funeral Home, P.A. 21. Signature of Furleral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 Heav 23a. Part1. Entar tha di pas shock, or heart failure. est, or complications that caused the east only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Deeth Cardiovascular Immediate Cause (Final diseasa or condition rasulting in death) crosc Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initioted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of geath? 1 Yes 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Yes 2 □ No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐XER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 20, 1998 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

State Registrar

1 Ose 31. Data filed (Month, Day, Year)

10

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32 Registrar's Signeture

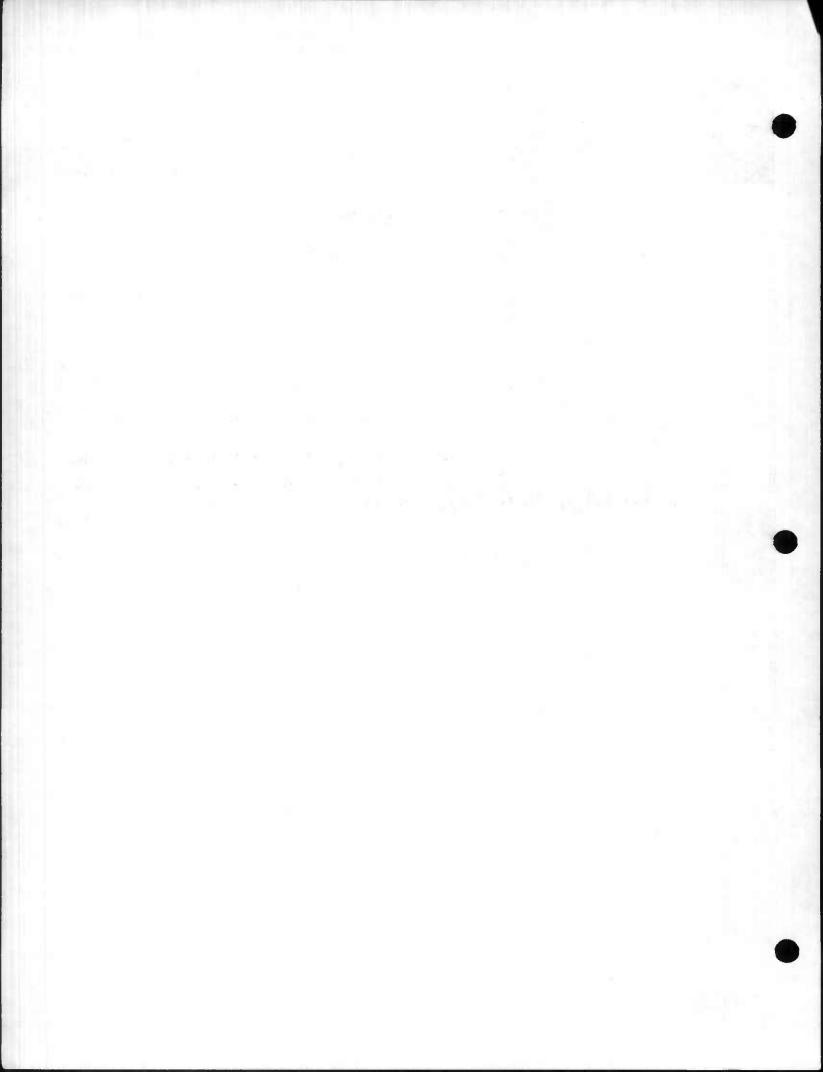
Penn Street, Baltimore, Maryland 21201

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**DEC 2 3 1998** 

				Ce	rtificate o	f Death	F	leg. No.	
hysician		Decedent's Nama (First, Middla, La					2. Data of Dea Month	Day	3. Time of Dear
/Medical	1		A. LIEFE	3			DEC. 2	20, 199	98 1:55
xaminer	r	la. Facility Name (If not institution, gi					r Location of Death		
	4	NATIONAL LU				ROCKV			TGOMERY CO
neral ector			Sax 7. Aga ( 1 □ M 2 X F	In yrs. last birthday) 93 Yrs.	Months Day			, Year)	Birthplaca (State or For Country)     WISCONSIN
	-	Usual Residence of Decedant  10a. State 10b. County							
notified at			MERY CO.	0c. City, Town or Lo	CKVILL	E			10d. Inside City Lir 1 XYes 2 □
nner must be notified Funeral Director	a Dild	10e. Street and Number 9701 – VEIRS	DRIVE		10f. Zip Code 2	0850		0g. Citizen of W USA	
þ	2	11. Marital Status  1 Never Marriad 2 Married  3 M Widowed 4 Divorced	12. Was Decedent Eve Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas:		Was Decedent of Yes, specify Co	f Hispanic Origin? ( uban, Maxicen, Pue lo <i>Specify:</i>	Specify Yas or No- rto Ricen, atc.)		- American Indian, c, White, etc. WHITE
Completed	inpication	15. Decedent's E (Specify only highast grade) Elementery/Secondery (0-12)	ducation ada completed) College (1-4or 5+)	16a. Deced (Giva life.	ient's Usual Occ kind of work dor DO NOT use reti	cupation ne during most of wi ired)	orking	16b. Kind of But	
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BeC	5	17. Father's Neme (First, Middle, Last	)			18. Mother'a Na	ame (First, Middla,	Melden Sumame	э)
To To		JULIUS LANGE				DORA I	BAXMANN		
other traumatic		19a. Informant's Name/Relationship (	***			et and Number or F			
		REV.DR. REICHA				IRS DR.			
any injury or ot	1	20a. Mathod of Disposition  1   ☐ Burial 2 ☐ Cramation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Control of Contro	Removal from State	20b. Place of Dispo cemetery, cren GREENWOOI	netory or other p				City or Town, State NIX, ARIZON
5 ei	-	21. Signature of Funeral Service Lice			. Name and Add	AL TARK			
any ir		1 1/2 No 20	44.6		HYSON	G CO., IN	VC.		
	+	23a. Part1. Enter the disease shock, or heart failure. Li only	polications that caused the	death Do not ent	1300-	N ST.,I	W, WASH	I.,DC	Approximate
ian	1	shock, or heart failure. Li only	one cause on each line.	1 0	or the mode of d	ying, such as cardie	A A	031,	Interval Between Onsat and Death
cal		Immediate Cause (Final	(1)	to Ko	50.40	Hone I	arten	0	10 mine
er		disaasa or condition resulting in daath)	a	00/0	Spira	10 49	accom	~	101141
ē			()	e to (or as a consec	uerice of)	1 7 1	21/11	0	month o
Examiner			b. Dy	to (or as a conseq		any	jariar		Months
EX		Sequentially list conditions, if eny, leading to immediata causa. Enter Underlying Cause (Disease or injury	2 + 2	to (or as a conseq	(3 01):	· 1164			110-0
		Cause (Disease or injury that initiated events	c. UV	100	41101	rillar	70m		years
Aedical Examir		esulting In death) Last	Dui	to (or as a conseq	uance or):				1
			d						
y Physicia		and the Cale of the Late of th							
Physician/		art it. Other significant conditions o	ontributing to death but n	ot resulting In the u	nderlying cause	given In Part I.	23b. Did to		tribute to the cause of dea 3 ☐ Probably 4 Unkn
d by							24a. Wes a	n autonsy	24b. Were eutopsy finding
Completed	-						perfor	ned?	available prior to complation of causa of death?
Comp	L						1 🗆 Y	s ZONo	1 ☐ Yes 2 ☐ No
a a		25. Was case referred to medical examinar?					ath (Check only on	e)	
To Be		1 Yas 2 No		2 ☐ ER/Outpatien	1 3□ DOA C	Other: 4 Nursing	Homa 5□ Reside	enca 6 🗆 Other	(Specify)
i.i.o	2	7. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day Ye	28b. Tima of Injury	28c. Inj	jury at ·	28d. Describe ho	w Injury occurre	d
and the last		2 ☐ Accident invastigation	1			☐ Yas 2 ☐ No			
le le	ч	3 ☐ Sulcide 6 ☐ Could not be	28a. Placa of Injury building, etc. (5	At home, farm, stre Specify)	eet, fectory, offic	28f. Location (Si City or Town		r or Rural Route Number,	
ertificat		4 ☐ Homicide determined			place, and due to the cause(s) and manner as stated				
lical Certification:		4 Homicide determined  9a. Certifier (Check only 2 Medical Exam	ysician: To the best of m	y knowledge, death amination and/or inv	occurred et the	time, date and plac opinion, death occ	e, and due to the coursed at the time, d	ause(s) end man ata and placa, ar	ner as stated.
Wedical Certificat	2	9a. Certifier (Check only one)  1 Certifying Ph 2 Medical Example 1		y knowledge, death amination and/or inv	estigetion, in my	opinion, death occ	urred at the time, d	ata and placa, ar	nd due to the ceuse(s)
Medical Certificat	2	4 Homicide determined  9a. Certifier (Check only 2 Medical Exam	ysician: To the best of m	y knowledge, death imination and/or inv	estigetion, in my	time, date and place opinion, death occurse number	urred at the time, d	ata and placa, ar 9d. Date signed	mer as stated.  Ind due to the ceuse(s)  (Month, Day, Year)  (M. 20, 1998
Medical Certificat	2	9a. Certifier (Check only one)  1 Certifying Ph 2 Medical Example 1	ysician: To the best of minar: On the basis of axe and manner stated	amination and/or Inv	estigetion, in my	nse number	urred at the time, d	ata and place, ar	(Month, Day, Year) My 20, 1998
pletaly fill	2	9a. Certifier (Check only one)  1 Certifying Ph 2 Medical Example and title of certifier	ysician: To the best of minar: On the basis of axe and manner stated	amination and/or Inv	estigetion, in my	opinion, death occ	urred at the time, d	ata and place, ar	(Month, Day, Year) My 20, 1998

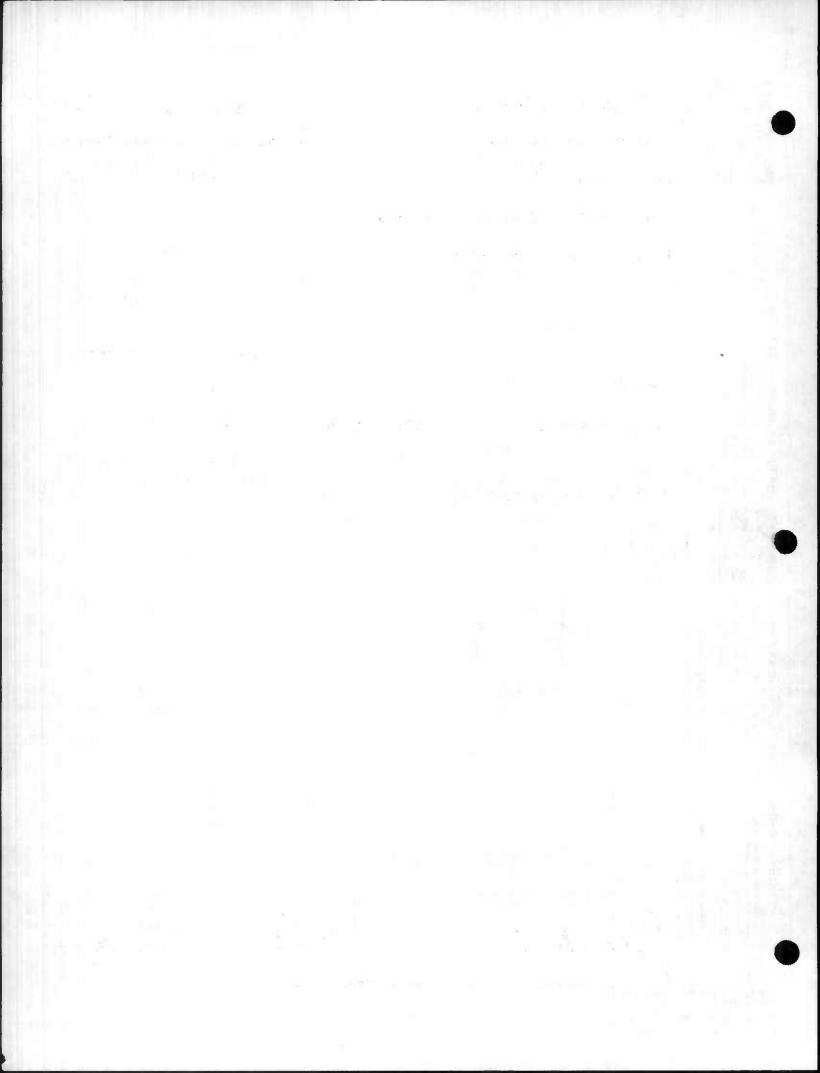
					Cert	ificate of	Death		Reg. No.				
Physici /Medi		1. Decedent's Neme (First, Mide Martha Loui:						Dec. 29		Yeer	3. Time of Deeth 8:25 a. m		
Examir		4a. Facility Name (If not institution  Avalon Manor						Location of Deetl	, , ,	4c. County of Deeth Washington			
Funeral Director		5. Social Security Number 213–18–9985	6. Sex 1 M 2 F	7. Aga (In yrs. la:		If Under 1 Yeer Months Days	if Under 24 Hr. Hours Mir				lace (Stete or Foreign) yland		
MOI TE		Usual Residence of Decedent  10a. Stete 10b. Count	у	10c. City,	Town or Loca	tion				1	0d. Inside City Limit		
L Day	ctor	Maryland Wash	ington		Smit	thsburg					1 ☐ Yes 2 ☑ N		
or 28	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen of \	Whet Cour	itry?		
23	rai	10 Blue Mounta				217			USA				
rai', or items 23a or 28a-f show Examiner must be notified at	by Funeral Director	11. Marital Status  1 Nevar Married 2 Me  3 Widowed 4 Divorce	rried Armed Fo	2₩ No		es Decedent of H es, specify Cubs	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	e - Amaric ck, White,			
natu	Completed	(Spacify only high Elementery/Secondery (0-12)	nt's Education est grade completed)	1-4or 5+)			ation during most of wi	orking	16b. Kind of B	usinass/Ind	dustry		
Hygie ther t	S	8 17. Fether's Neme (First, Middle	Lact		h	omemake:		eme (First, Middle		ome			
and Mentel ? Is marked of raumatic ave	To Be	Franklin A.						. Delaut		16)			
mark	F	19a. Informant's Name/Relation			19b. Meiling	Address (Street		Rurel Route Numb		Stete, Zip	Code)		
Heelth a tam 27 is other tra		Joseph Monn		Son 2	1748 L	eitersb	urg Pike	Hagerst	own, Ma	rylar.	d 21742		
r itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Demoval from	20b. Ple	ce of Disposit	ion (Neme of tory or other plea	:0)	Date	20c. Location -	City or To	wn, Stete		
ment of the ant: If its uny or of		4 Donation 5 Other (		Cedar	Lawn M	emorial Pa	ark	12/31/98	Hagerstow	n, Mar	yland		
Department of Heelith and Mentel Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, The Monee.		21. Signature of Funerel Service Licansee  22. Name and Address of Fecility.  Gerald N. Minnich  Funeral Home  23. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate shock, or heart feilure. List only one cause on each line.  Approximate interval Between the caused the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between the caused the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between the caused the deeth.											
ysician Medicai aminer	Examiner	immediate Cause (Final disease or condition resulting in deeth)		Due to (or e	mal	n te	Pres	mana		-	Onsat and Death		
ettending physician and d for use as the bunat-transit	edicai	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disesse or injury that initieted events resulting in deeth) Lest	c		es e conseque								
the ette	Physician/M	Part II. Other eignificant conditi							tobacco use co	ntribute ic	the cause of deat		
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s been sign 2 should be	Completed by	Direct C	han's	Reme	rany	namo		24a. Wes	an eutopsy ormed?	sv.	ere autopsy tinding allabla prior to mpletion of causa death?		
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is certificate director, pag	Be	25. Was case referred to medica examiner?						eth (Check only	one)				
After this funeral di	Other: 4 Nursing Homa 5 Rasidence 8								y)				
s anter oeaun. If Director: A ad in by the fe	Certification:	3 Suicide 6 Could	not be	of Injury - At hom ng, etc. (Specify)	a, farm, strae			28f. Location ( City or To	Street end Numb wn, Stete)	er or Rura	l Routa Number,		
To the Funeral Dir completely filled in	edical (		ng Phyelclen: To the Examiner: On the ba										
Toth	M	29b. Signature and title of certific	ır			29c. Licens	e number		29d. Dete signe	d (Month,	Day, Year)		
		<b>)</b> —	Jalt my			D (	8019		PAC 2	-9, 0	875		
		30. Neme end address of person	who completed caus	e of deeth (Item 2	3e) (Type Pr	int)							
		Vasant Dat					gerstown	, Maryla	nd 21740	)			

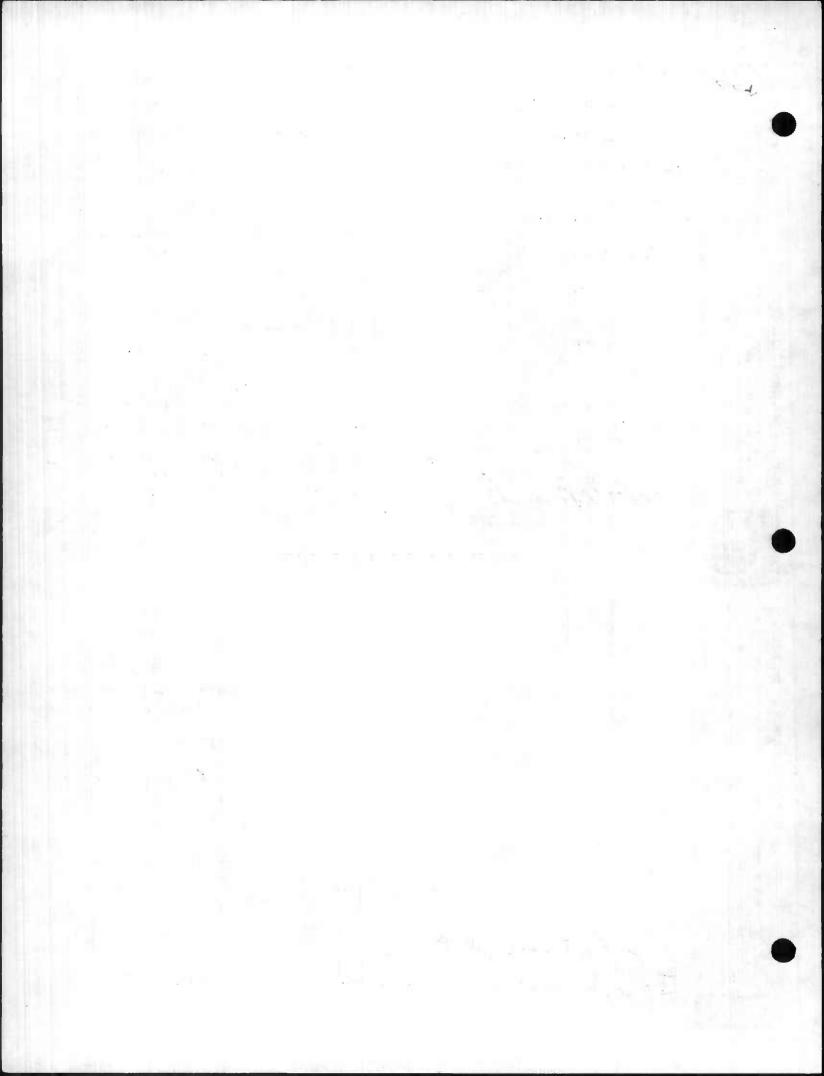


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	State of Maryland / Department of Health and Mental Hygiene	6	0
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4a. Facility Nama (  Marin  5. Social Security N  21/20  10a. Stata  Md  10e. Street and Nu  14200  11. Marital Status  1 Navar Marr  3 Widowed  (Spect  Elemantary/Secc  10  17. Fathar's Nama  Unkn  19a. Informant's Na  Kathle  20a. Method of Disj	er Nurs 2663 Decadent 10b. County Prince mbar Laurel ied 2 Married 4 Miorced 15. Dacadant's Ecity only highast greendary (0-12) (First, Middla, Last)	George  Park Dr  1 Was Dacede Armed Force 1 Was, Giva Yaar or Data  Jucation da complated)  Collega (1-4c)	er) e Aga (In yrs 79 10c. C s ive int Ever in Use? XNo	Yrs ity, Town o	r Location rel,  10f. 2	Md.	Hours Mir	, Md.	Day 2 P th 4c. Count Prin	10 X	3 / eorg	a or Foraign
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19a. Informant's No.  Kathle 20a. Method of Disp 1 ₽ Burial 2								ma (First, Middle			ULUI	
Kathle 20a. Method of Dis 1 ₽ Burial 2	me/Relationship (						Lan	ra Jon	0.0			
Kathle 20a. Method of Dis 1 ₽ Burial 2		Type, Print)		19b. M	alling Addra	ss (Street	and Number or F			State Zin	Code )	
20a. Method of Disp 1 ₩ Burial 2	T											
1 Burial 2		8	20b.	Place of Di	sposition (A crematory o	we Di	ry Dr.	#34Lau:	20c. Location	City or Toy	vn Stata	
4 Donation	Cremation 3	Removal from Sta	110			r othar pla		, , ,				
21. Signatura of Fu			Се	dar				1/2/99				•
17	anyt	Wate	Ton		24 W	. Ве	ethel S	_	erstow			740
23a. Part1. Entar to shock, or haa		plications that caus ona causa on aach						c or raspiratory a	rrast,		Approxim Interval B Onsat en	etween
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rasulting in death)			Dua to	or as a con	sequence o	f):						
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Secuentially liet or if any, leading to imcause. Enter Under Cause. (Disease or	rottions, mediate rhying		Dua to [	or as a con	saujuence o	):				Sac		
that initiated events resulting in death) I	ast	Due to (or as a consequence of):								-		
Part II. Other significant conditions contributing to death but not resulting in the												
Part II. Other signif	cant conditions of	ontributing to death	eath but not resulting in the underlying cause given in Part I.					23b. Dld	entribute to	fibute to the cause of death?		
								10	Y00 20 (No	3 Prob	ably 4(	Unknow
								24a. Was	an autopsy ormed?	avai	ilable prio	rto
								10	Yas 2000	10	Yas 2	ZNo.
	ed to medical						28. Place of De					- (
	No	Hospital:	tiant 2	RR/Outna	tiant 3 C	OA Oth	ar L			har (Snanih)	1	
27. Manpar of Death		28a. Data of Ir	njury	28b. Time	a of			7		111111111111		
			Jay Tear)	Injur	M							
3 ☐ Suicida 4 ☐ Homicida	6 Could not be datarmined	28a. Place of I	njury - At h atc. <i>(Spacil</i>	oma, farm,	straat, facto	ery, office				ber or Rural	Routa Nu	m <i>ber</i> ,
29a. Certifiar (Check only one)	12 Certifying Phy 2 Medical Exam	iner: On the basis	of axamina	owiedga, da ition and/or	ath occurre invastigatio	d at tha tin n, in my o	na, data and place plnion, daath occi	e, and dua to tha urred at tha tima,	causa(s) and m data and place,	annar as sta and dua to t	ited. tha causa	(0)
29b. Signatura and	titla of certifiar/	•	21714		2:				29d. Data signe	ed (Month, D	ay, Yearl	
1 An	An Kes	wD							1			20
7/100							7,0		mella	v as	,179	18
A .			01.		e, Print)						, .	
Andrew Kundpit, MD. 8317 (KARY LAW, LAURGE, MO.												
F 2	Immediata Causa (disaasa or condition rasulting in death)  Sequentially liet or if any, leading to incause. Enter Unde Cause (Disease or that intitated events resulting in death) L  Part II. Other significant of the cause of t	Immediata Causa (Final disease or condition rasulting in death)  Sequentially liet	Immediata Causa (Final disaasa or condition rasulting in death)  Sequentially liet and times if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  25. Was casa rafarred to medical axaminar?  1	Immediata Causa (Final disease or condition resulting in death)  Seventially liet and time of the property of	Immediata Causa (Final disaasa or condition rasulting in death)  Dua to for as a condition fit any, leading to immediate cause. 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Was cass referred to medical axaminar?   1   Injury that   1   Injury tha	Immediate Cause (Final disease or condition resulting in death)  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  Due to for as a consequence of final death point in the underlying cause given in Part I.  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November 95

Physicia /Medic Examin	al	Decedent's Nama (First, Middle,     Pauline Daphne     Aa. Fecility Nema (if not institution, 111 W. Baltimore)
more, Mar Pages 1 and 2 sh nent of Health and nnt: if Nem 27 le m nry or other traum	To Be Completed by Funeral Director	5. Social Security Number 220-18-1514  Usual Rasidance of Decedant 10a. State 10b. County Maryland Wash: 10e. Street and Number 11 W. Baltimore 11. Meritel Stetus 1 Nevar Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's (Specify only highest (Specify only highest (Pirst, Middle, La Joseph C. Miller) 19e. Informant's Neme/Ralationship Betty J. Wolfe 20e. Method of Disposition 1 Description 1 Community Specification 3 4 Donation 5 Othar (Specification)
Baltim permit. Pat Department: Important: any Injury sance.		21. Signeture of Funaral Service Lic 23e. Part1. Entar tha diseese, or co shock, or haart feilure. List on
Physician		

							LIG.	g. No.			
Decedent's Nama (First, Middle Pauline Daphne		G					2. Deta of Death Month December	Day	Year 1998	3. Tima of 1:40	Death a.m.
Fecility Nema (if not institution	, give street and nu	imber)			4b. City, To	wn, or L	ocation of Deeth	1	y of Deeth		
11 W. Baltimo	re St., A	pt. 126			Hagers	stow	n	Was	hingt	on	
Social Security Number 220–18–1514	6. Sex 1 ☐ M <b>X</b> F	7. Aga (In yrs. 93	last birthdey) Yrs.	If Under 1 Ya Months Da		24 Hrs. Min.	8. Data of Birth (Month, Day, June 18	Year)	9. Birth	place (State or ntry) yland	Foreign
ual Rasidance of Decedant a. State 10b. County faryland Wasi	hington	10c. City	y, Town or Lo	cation agersto	wn				1	10d. Inside Cit	
e. Street and Number	e St., Ap	t. 126		10f. Zip Cod	1740		10	g. Citizen of	What Cour	ntry?	
Meritel Stetus  1 Nevar Married 2 Merr  3 Widowed 4 Divorced	Armed F	2₹ No iva		Ves Decedent ( I Yes, specify C	uban, Maxicer	n, Puerto	pecify Yes or No- Rican, atc.)		ick, White,	can Indian, atc. nite	
15. Decedent (Specify only highes	t's Education st grade completed)		(Give	ant's Usual Oc kind of work do	ne durina mos	t of work	king 1	6b. Kind of E	Businass/In	dustry	
Elamantary/Secondary (0-12)	Collega (	1-4or 5+)		nemaker	ired)			her	own	home	
Father's Neme (First, Middle, Joseph C. Mille							a (First, Middle, M Kline	faiden Surna	me)		
e, informant's Neme/Ralations Betty J. Wolfe		er	10.000				Apt. 126				21740
e. Method ot Disposition 1⊠ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (S)		Steta	emetery, crem	sition (Name of netory or other)	olace)	1:	Data 2 2-28-98	Hager:		own, Steta	and
Signeture of Funaral Service	Licensee Men.	mel	1	Name and Ad			MINNICH I				
Se. Part1. Entar tha diseese, or shock, or haart feilure. List	complications that only one cause on	ceused tha daat aach lina.	. Do not ante	er the mode of	tying, such es	cardiac	or respiratory arre	st,	1	Approximate Interval Betw Onset and D	reen

/Medical Examiner

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Be

Certification: To

Medicai

Division of Vital Records, P.O. Box 68760,

Examiner Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Ceuse (Disaase or injury that initiated evants resulting in death) Last Physician/Medical Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Completed

Immediata Ceuse (Final disaasa or condition resulting in daath)

Dua to (or es a consaquance of): Dua to (or es e consequence of): Dua to (or as a consequence of):

Cancer of the colon

				24a. Was an autopsy performed?	24b. Wara eutopsy findings available prior to completion of cause of death?
25. Was case refarred to medical axaminar?			28. Place of De	eath (Check only one)	
1 ☐ Yas 2 🗷 No	Hospitel: 1 Inpatiant 2	☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing	Homa 5 Nasidance 6 □Oth	er (Specify)
27. Mannar of Deeth  1 ☒ Netural 5 ☐ Pending 2 ☐ Accidant investigation			injury at Work? 1 ☐ Yas 2 ☐ No	28d. Describe how injury occurs N/A	red
3 Sulcida 6 Could not datarmine		homa, ferm, street, fectory, cify)	office	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
29a. Certifiar (Check only one)  1. Certifying P 2	hyalcfan: To tha best of my k miner: On tha basis of axami end mannar steted.	nowledge, death occurred at nation and/or invastigation, is	tha tima, data end plec my opinion, daeth occ	ce, end dua to tha causa(s) end me curred at the time, data end plece,	ennar as stated. and dua to the ceuse(s)

		F	an
30.	Nama	and	addres

29b. Signatura end titla of certifier

cico G. Japan, m.D.

29c. Licansa number D05821

29d. Dete signed (Month, Dey, Year) 12/23/98

23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown

ss of person who complated causa ot daath (Itam 23a) (Type, Print)

Francisco G. Japson, M.D., FACS, 346 Mill Street, Hagerstown, Md. 21740

31. Data tiled (Month, Day, Year)

32. Registrar's Signature 31. Data tiled (Month, Day, Year)

State Registrar

(株) (2011年) The lands of the second of the 1 × 1 LA 30 . 0 0 . . 34 

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Macral Examinar must be notified.

**Physician** /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Director

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ks Mitchel	Ll	State of	Maryland		rtment of tificate of		Mental Hy		41166			
1. Decedent's Nam	e (First, Middl	a. Last)		007	iniouto or	Dodan	2. Date of D	Reg. No.	3. Time of Death			
	JONATH		ROOK	M	ITCHELL		Month December Location of Dea	Dey Der 29.	Year 1998 3:34 P.M.			
	Ocean,	6 miles e			City If Under 1 Yeer Months Days	Ocean C	rs. 8. Dete of B	Worces				
Usual Residence of	-											
MD .	WORCE:	STER		Town or Loc	CITY				10d. Inside City Limits 1 ☐ Yes 2 KNo			
10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of	What Country?			
9623 W.	FOUR	TH STREET			218	42		US	A			
11. Merital Stetus 1 Nevar Marri		12. Was Deced Armed Ford	ant Evar in U,S. as? ☑No			Hispanic Origin? ben, Mexican, Pus	(Specify Yas or Narto Rican, atc.)		ce - American Indian, ck, White, etc.			
3 ☐ Widowed	4 Divorced	Year or Det	es:		LI 165 ZONO	Specify.		Specif	WHITE			
		st grada completed)		16a. Decede (Giva k lifa. D	ent's Usual Occu ind of work done O NOT use retin	pation a during most of weed)	vorking	16b. Kind of B	usiness/Industry			
Elementary/Seco 12 17. Father's Nama		College (1-4	tor 5+)	FI	SHERMA	RCIAL FISHIN						
ROBERT	МІТС	HELL				JOANN	WILLIA	AMS				
The state of the s	19a. Informant's Name/Ralationship (Type, Print)  AMY S. MITCHELL SPOUSE						Rural Route Numi		11 01010			
						H STREE						
20a. Mathod of Disp 1 Burial 2 4 Donation	Cramation	3 □Removel from Si	ete	natary, crem	ition (Nama of atory or other pla Y CREA		Date 12-31		BURY, MD.			
21. Signature of Fu	Ingral Service	Licensee	JUAL	22.	Nama and Addr			BERLIN				
23a. Part t. Enter to shock, or has	he disaesa, or irt failure. List	complications that car only one causa on aac	used the death. ch lina.					arrest,	Approximate Interval Between Onset and Death			
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		d							t			
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated evants rasulting in death) I	icant conditio	ma contributing to dea	th but not rasult	ing in the un	darlying causa g	iven in Part I.		tobacco use co	antribute to the cause of deeth?			
							24a. Wa	s an autopsy formed?	24b. Wara autopsy findings available prior to completion of cause of death?			
				91			100	Yes 2 No	1 Yes 2 No			
25. Was casa rafan	red to medical						eath (Check only	ona)				
examiner? A(2) Yas 2 □  27. Mannar of Deatl 1 □ Natural 2 □ Accident 3 □ Sulcide	h 5 Pandin invastig 6 Could r	pation 12/2		R/Outpatient 8b. Tima of Injury	M 1	ner (Specify)						
4  Homicida	detarm	inad   288, 11808 0	f injury - At hom , atc. (Specify)	ne, ferm, stre	et, fectory, office		2 M. Location City or To	own, Stata) A+	en lite Mare Land			

29b. Signatura and titla of certifier

29c. Licensa number

29d. Deta signed (Month, Day, Year)

O.C.M.E.

December 30, 1998

30. Name and address of person who completed cause g daath (ttem 23a) (Type, Print)

THEODREM. KM
31. Data filed (Month, Day, Year)
DEC 3 1 1998 10

111 Penn Street, Baltimore, Maryland 21201

State Registrar

----- - J. J.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month PETER PRETTYMAN MASON , JR. 1998 DEC 27 6:00 AM 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Deeth NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Hours Min. 8. Dete of Birth (Month, Dey, You 11/5/23 6 Sax 7. Age (In yrs. lest birthday) If Under 1 Year Birthplaca (State or Foreign Country) 1 M 2 □ F Months Deys 75 215-14-3441 Yrs Maryland Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Worcester Snow Hill 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? U.S.A, WorcesterCty. 5952 Basketswitch 21863 Road 12. Wes Decedent Ever in U.S.
Armed Forces? 1940 —
15 Yes 2 □ No
If Yes, Give
Yeer or Detes: 1960 — Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, atc. 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ocean City Elementary/Secondery (0-12) Collaga (1-4or 5+) Maintenance Work Condominium Assoc. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Peter Prettyman Mason, Sr. Annie Payne (Mason) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5952 Basketswitch Rd., Snow Hill, Md. 21863 M. Margaret Mason 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 12/31 20c. Location - City or Town, Stete 1 □ Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veteran's Cemetery Hurlock, Md. 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility P.O. Box 87 De Dennis Funeral Home, Snow Hill, Md. 21863 air mus 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only ona cause on each lina. Approximete Interval Between Onset and Death Immediate Cause (Final ESOPHAGEAL CANCER disease or condition resulting in deeth) Due to (or es a consequance of) Due to for as a consequence of: Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

ician and burial-transit

physician s the burial

signed by the a d be detached f

page 2 hes certificate

funeral

filled in by

Medical

29b. Signeture end title of certifie

JEFFREY TJADEN,

38

Box 68760. death certificate be

P.O.

Records.

Division of Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

24 hours a

To the Vithin 2

**Physician** 

/Medical

Examiner

Md.

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Director

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Completed

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**Funeral** 

Director

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filed within 72 hours after

Pages 1 end 2 should be filed within tent of Heelth end Mental Hygiene. nt: If item 27 is marked other than "

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permit. Pag Department Important: If any Injury o

Saltimore, Maryland 21215-0020

Physician/Medical by Completed B P Certification:

E aquarmally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes cesa referred to medical 28. Place of Deeth (Check only one) Hospitel: X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end place, end dua to the cause(s) and manner es steted.

Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceusa(s) end menner steted. 29a, Certifie (Check only one)

State Registrar

LT, 31. Dete filed (Month, Day, Year) **DEC 2 9 1998** 

30. Name and address of person who completed ceusa of daath (Item 23a) (Type, Print)



M.D

BETHESDA MD 20889-5600 oouts

29c. License number

8294 (MT)

NATIONAL NAVAL MEDICAL CENTER

29d. Dete signed (Month, Day, Year) Dec, 28, 1998

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Messick 0025 12 Leodore 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F Months Days Hours Yrs. **Director** 222-10-2910 84 Delaware Sept 5, 1914 Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 No Directo DE Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rd 4 Box 73 19956 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural; or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 ☐ Never Married 257 Married 1 ☐ Yes 21 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nylon Company Store Clerk 12 18. Mothar's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Charles W. Messick Ethel Hastings Messick 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19956 Janet Messick Wife Box 73 Laurel, DE Rd 4 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery 12-29-98 Laurel, Delaware 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Short Funeral Home William 1 23a. Part1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on ach line. Laurel, DE 19956 Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) Esophagen (a.
Due to (or as a consequence of): /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 2 NO 3 Probably 4 Unknown 1 Yes p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? his certificate has bit director, page 2 sl ...ospital or Attending Physician: The Yans after death.
The Funeral Director: After this added in the Funeral Director of the physician of the filled in by the formal part of the filled in by the formal part of the filled in by the formal part of the formal part of the filled in by the formal part of the formal par 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) tient 2 ER/Outpatient 3 DOA 2 27 Manner of Peath ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 126278

To the Hosp within 24 ho To the Fune completely fi

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

with the Maryland

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State Registrar Dourd

31. Date filad (Month, Day, Year) DEC 2 9 1998

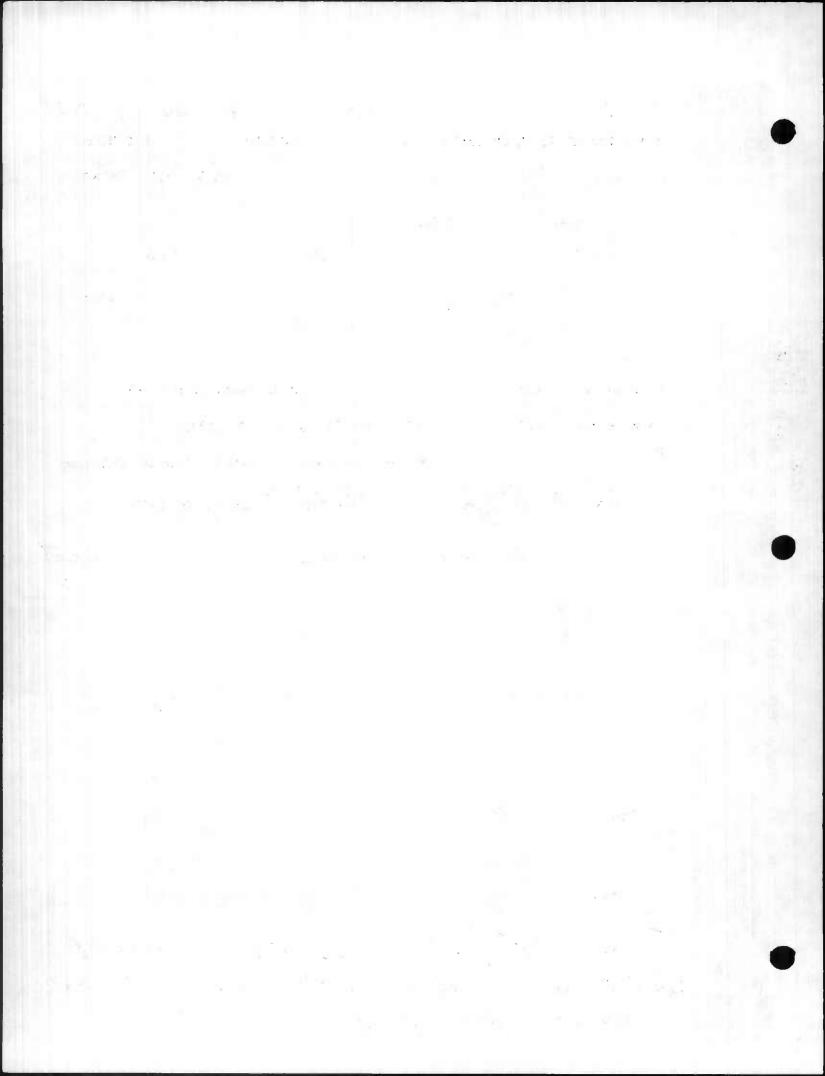
30. Name and address of person who completed care of death (Item 23a) (Type, Print)

MD 145 32. Registrar's Signature

Carroll St. Solist, MA 21861

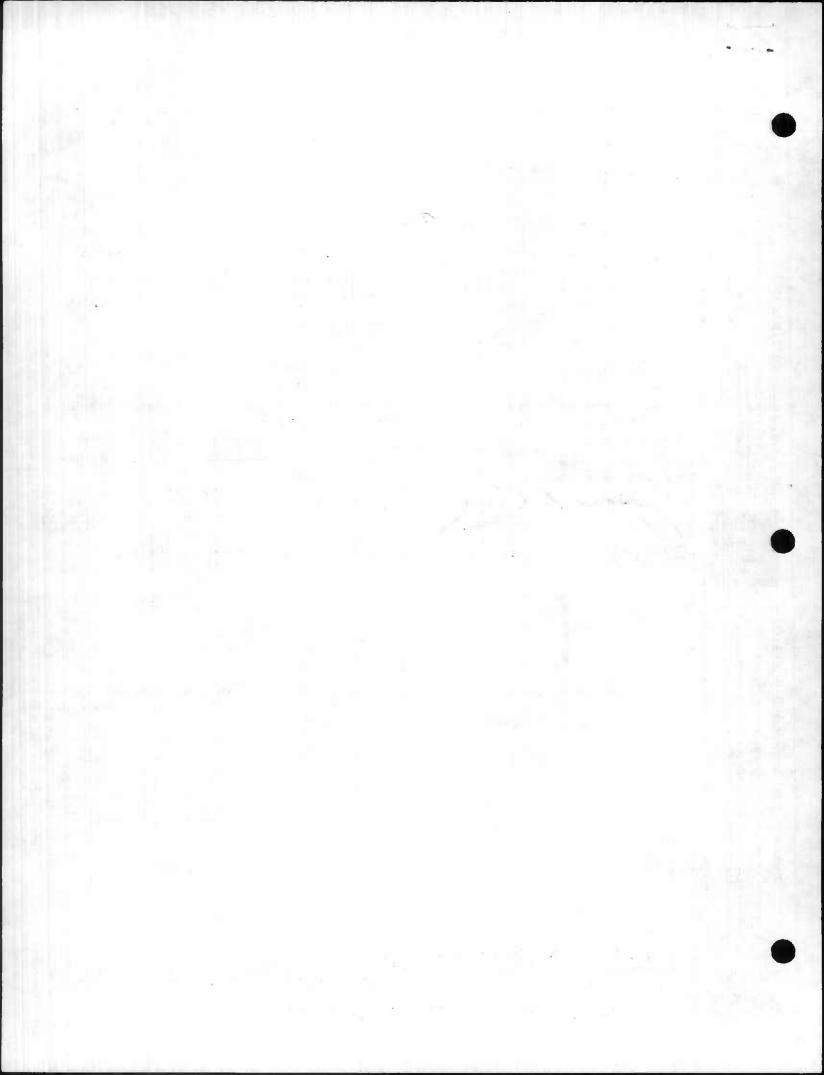
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**DHMH 16 Rev 6/95** 



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		Sal	em Churc	ch Ceme	etery	De	c. 28	Westm	inste	r, Maryland
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	plications that caused the	death.	Do not enter the	mode of dyir	ng, such as ca	ardiac or	respiratory a	rrest,	ru - ru	Approximeta Interval Between
isease or condition	8.				tic Cai	rdio	vascul	ar Dise	ease	
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				29c. Licens	se number	777		29d. Dete sign	ned (Month,	, Day, Year)
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Atysy &	Ma	de	5, MD	0.0	C.M.E.			Decembe	r 27,	1998
Do. Signature and title of certifier  August 1997  D. Name and address of person who is tephen Radentz, I		c/l				oot-				1998 and 21201
	Pauline E. Mu.  In Facility Name (If not institution, given to be a part of the part of th	Pauline E. Muller  a Facility Name (if not institution, give street and number)  5908 Grace Lee Avenue  Social Security Number  212-24-6289  Javal Residence of Decedent  10e. State  10b. County  Maryland  Carroll  Oe. Street and Number  5908 Grace Lee Ave.  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Everage of Decedent Everage of Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7 th grade  7. Father's Name (First, Middife, Last)  Charles E. Hoff, Sr.  19a. Informant's Name/Relationship (Type, Print)  Hobart Muller Son  10a. Method of Disposition  1 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Java State (Finel disease, or complications that eards of the shock or heart failure. List only one cause on mach line.  Mary leading to immediate acuse. 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Muller  a Facility Name (If not institution, give street and number)  5908 Grace Lee Avenue  Social Security Number  212-24-6289  Jaual Residence of Decedent  10e. State  10b. County  Maryland  Carroll  Sy  10e. Street and Number  5908 Grace Lee Ave.  11. Marital Status  1 Never Married  3 til Nover Married  3 til Nover Married  3 til Nover Married  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  7 th grade  7. Father's Name (First, Middle, Last)  Charles E. Hoff, Sr.  19a. Informant's Name/Relationship (Type, Print)  Hobart Muller Son  10a. Method of Disposition  1 til Reurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22a. Part I. Inter the disease, or complications the autised the death, shock or heart failure. List only one cause on mediate ausse. Enter Moderly in the death)  Sequentially list conditions, any, leading to immediate ausse. 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Marital Status  13. Wes Information 15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Give liter's file. Do N  17. The grade  7. Father's Name (First, Middie, Last)  Charles E. Hoff, Sr.  19a. Informant's Name/Relationship (Type, Print)  Hobart Muller  19b. Mailing Ad  396 Rife  19c. Decedent's Give liter's file. Do N  20b. Place of Disposition 15 Burial 2 Coremation 3 Removal from State 4 Donation 5 Onther (Specify)  19a. Marital Enter Dividerlying has been deceded by the death. Do not enter the shock or heart failure. List only one cause on heak line.  Due to (or as a consequence condition and the proving in death)  19a. Due to (or as a consequence condition and the proving in death)  19a. Due to (or as a consequence condition and the proving in death)  21. Signature of Death  22. 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Father's Name (First, Midde, Last) Charles E. Hoff, Sr.  19. Informant's Name/Relationship (Type, Print) Hobart Muller Son  Observed Consequence of Decadent Street and Number 20. Method of Disposition 16. Mailing Address (Street and Number 396 Rife Road East 4 Donation 5 Doher (Specify)  18. Mailing Address (Street and Number 396 Rife Road East 4 Donation 5 Doher (Specify)  19. Mailing Address (Street and Number 396 Rife Road East 4 Donation 5 Doher (Specify)  19. Mailing Address (Street and Number 396 Rife Road East 4 Donation 5 Doher (Specify)  19. Mailing Address (Street and Number 396 Rife Road East 4 Donation 5 Doher (Specify)  19. 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Muller    Facility Name (if not institution, give street and number)	Pauline E. Muller    Pauline E. Muller

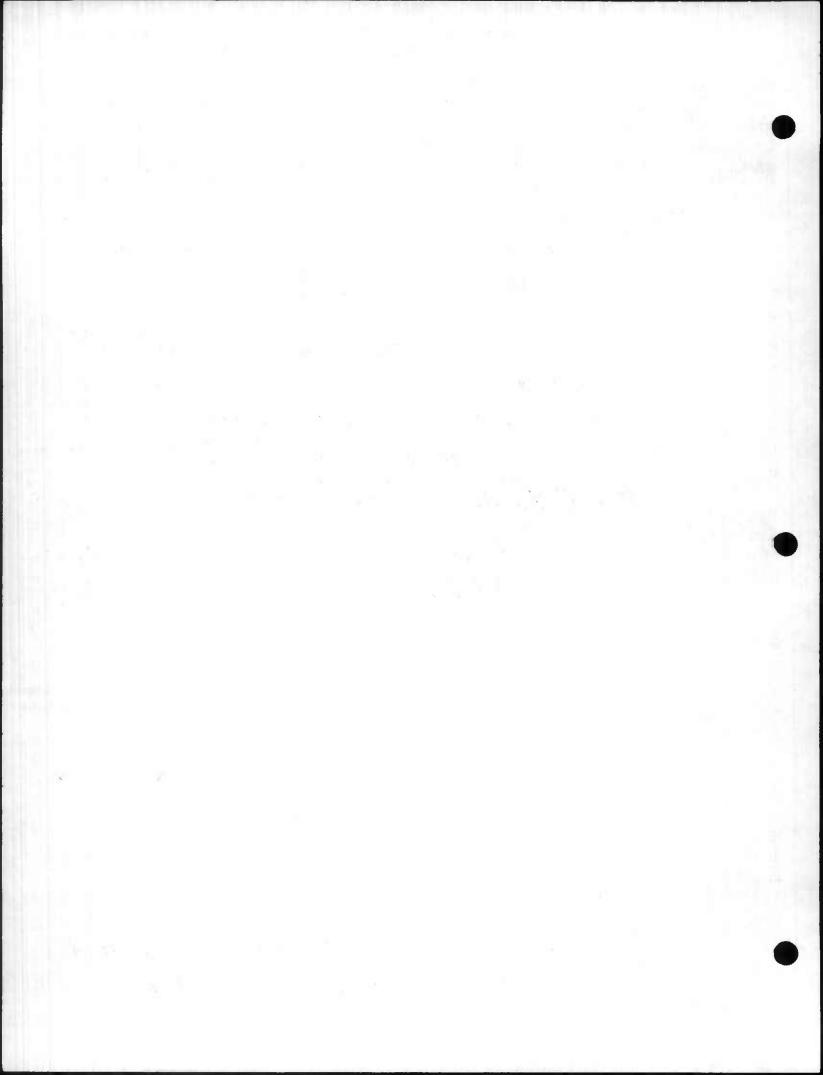


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene	5	14	
Cartificate of Double			

					Cei	rtifica	ate of	Death		Reg	No.		
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Funeral Director		5. Social Security Number 213-01-3146	6. Sax 1 □ M 2 🗓 F	7. Age (In yn	s. last birthday) Yrs.	Month.	ar 1 Yaar s Deys			of Birth oth, Dey, Y.	94r) 1915	9. Birthp Court MARY	olaca (Stete or Fo
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ding physicia	√Medical Examiner	Immediata Causa (Finel disease or condition resulting in death)  Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. A b. A c	lyh	(or es e consequence of consequence of consequence or as a consequence of consequ	uence o	f):						1 cut
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3 4 4 5	Certification:	3 Suicida 6 Could no determin	led 28e. Pieca	of Injury - At I	nome, farm, stra ify)	aat, facto	ory, offica			ation (Stree or Town, S		per or Rura	il Route Number,
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within 7 to the comple	Ň	29b. Signeture end title of certifier				2	9c. Licen	sa number		29d.	Data signe	d (Month, i	Day, Year)
		30. Nema and address of person w	nullta	so of death (Ite	m 23e) (Tvne	Print) a	Da	544	3 NETA	No M	12/	24/	98
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Sta Registr		31. Dete filed (Month Day Year)	1998 <sup>32. R</sup>	egistrar's Sign	ature /	1.	Spa	ch		· · ·	-		

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar KATHRYN ANITA MICHAEL DEC. 14, 1998 9:50 PM. 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WESTMINSTER NURSING HOME WESTMINSTER | H Undar 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | 3 / 2 9 / 1 9 0 3 5. Social Sacurity Number If Undar 1 Year 7. Aga (In yrs. last birthdey) Birthpiaca (State or Foreign Country) Months Days 1□ M 25 F 95 Yrs. 216-46-6184 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5 SPRING GLEN COURT 21030 USA. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American indian, Biack, Whita, atc. 1 ☐ Nevar Married 2 ☐ Marriad 1 ☐ Yes 2X No Specify: Specify: 3X Widowad 4 □ Divorced WHITE 16a. Decedent's Usuai Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKING 17. Father's Name (First, Middia, Last) 18. Mother's Nama (First, Middle, Meiden Sumema) EDWARD L. DOUGHERTY BESSIE ANITA RITTER 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) STANLEY MICHAEL, JR.-SON 5 SPRING GLEN CT., COCKEYSVILLE, MD. 21030 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removei from State 4 Donation 5 Other (Spacify) ENTOMBMENT LORRAINE PARK CEM. 12/17/98 BALTIMORE, MD. 22. Name and Addrass of Facility FLETCHER FUNERAL HOME 21. Signatura of Funeral Sarvice Licensee 254 E. MAIN ST., WESTMINSTER, MD. da 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown

Examiner The law requires that the death certificate be executed buriel Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as signed by the a Be Completed by s certificate has b director, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Department of Health elimportant: If Item 27 is any injury or other traconce.

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/Medical **Examiner** 

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Medical Examiner must be notified at

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Pages 1 and 2 should be nent of Health end Mental

Baltimore, Maryland 21215-0020

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Corone	vey Arten	y Disca	se.	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
25. Was cese referred to medicei			26. Place of D	eath (Check only one)	
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27. Manner of Death  1 Natural 5 Pending 2 Accident investige	28a. Data of Injury (Month, Dey Yaer)	28b. Time of injury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	
3 ☐ Suicide 6 ☐ Could not determine		nome, farm, street, fac	tory, office	28f. Location (Street and Num City or Town, Stete)	ber or Rural Routa Number,
29a. Certifier (Check only one) Certifying   Certifying	Phyeician: To the best of my kni aminer: On the basis of examine and manner stated.	owledge, death occurr ation and/or investigat	red at the time, dete and place tion, in my opinion, death occ	ce, end due to the ceuse(s) and m curred et the time, date end place,	anner as stated. and due to the cause(s)

State Registrar

Medicai

31. Data filed (Month, Dey, Year) DEC 2 8 1998

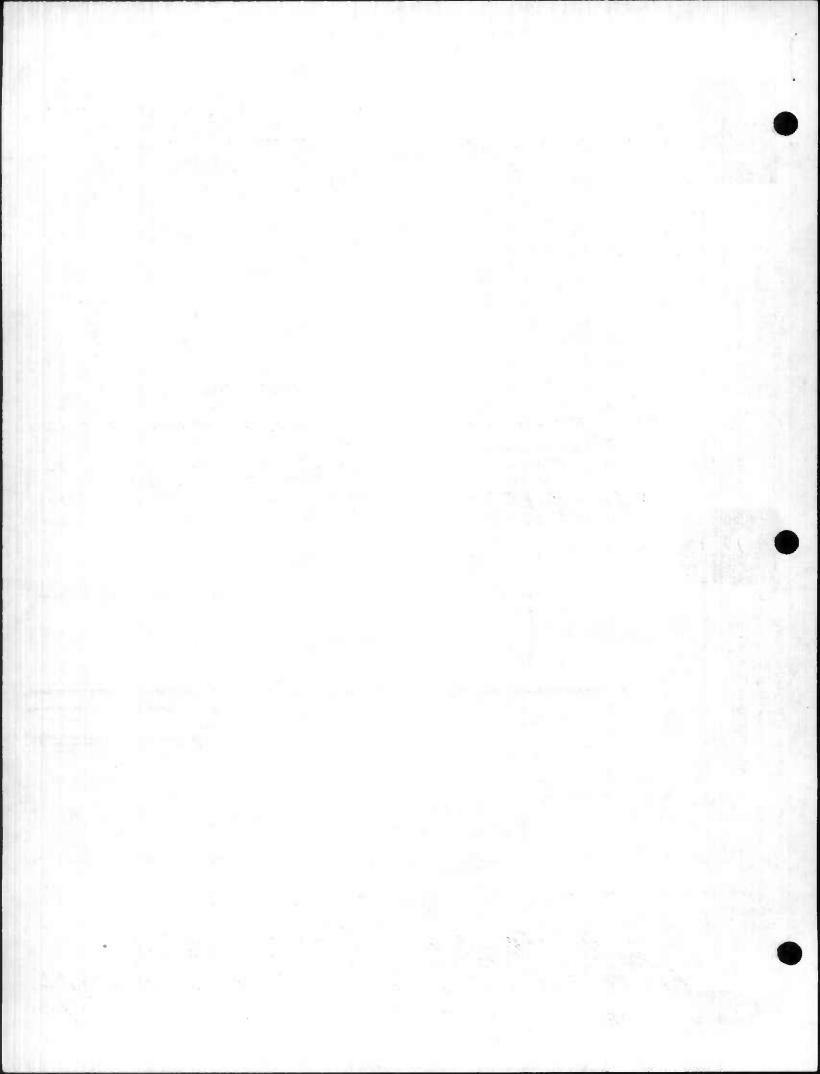
29b. Signature and title of certifier



and address of person who completed cause of death (Item 23a) (Type, Print)

anse number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** 1900 McCollister Charlotte Elaine WEC 32 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Aga (In yrs. last birthday)
71 Yrs. If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
71 Aga (In yrs. last birthday)
8. Date of Birth (Month, Day, Year)
71 April 11,1927 Birthpiaca (State or Foreign Country)
 Mass. 5. Social Security Number **Funeral** 1 M XXF 025-20-2430 Director Usual Residence of Decedent 72 hours after deeth with the Meryland 10b. County 10c. City, Town or Location 10d. Insida City Limits filed within 72 hours after deeth with the Menylen Hydene. Hydene, but he than "natural", or flerns 23a or 28a-f show ent, the Wed sail Examines must be notified as 1 ☐ Yes 2XXNo Cambridge Director Maryland Dorchester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3220 Indian Bone Road 21613 US Funeral 12. Was Decedant Evar in U,S. Armed Forcaş? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White Specify: þ 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Department of Health end Mentel Hygis Important: If Item 27 le marked other any Injury or other traumatic event, is 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be Peges 1 and 2 should be Ted Brusso Laura Love 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granville F. McCollister Husband 3220 Indian Bone Road Cambridge, Maryland 21613 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cramation 3 □ Ramovai from Stata 12/27 Green Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 exitte 23a. Part 1. Enter the disease, or complications that cause it is death. Do not enter the mode of dying, such as cardiac or respiratory eshock, or heart failure. List only one cause on each one. Approximata Interval Between Onsat and Death **Physician** /Medical Immediete Ceuse (Finel heel Nemans disaase or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner 2057 the deeth certificate be axecuted physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last runt H) P.O. Box 68760. Physician/Medical Dua to (or as a consequence of):( attending pl signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ils certificate hes t director, page 2 s to Vac or all 1 □ Yes 2 □ No Mospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certificalety filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicida 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/23/98 My 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

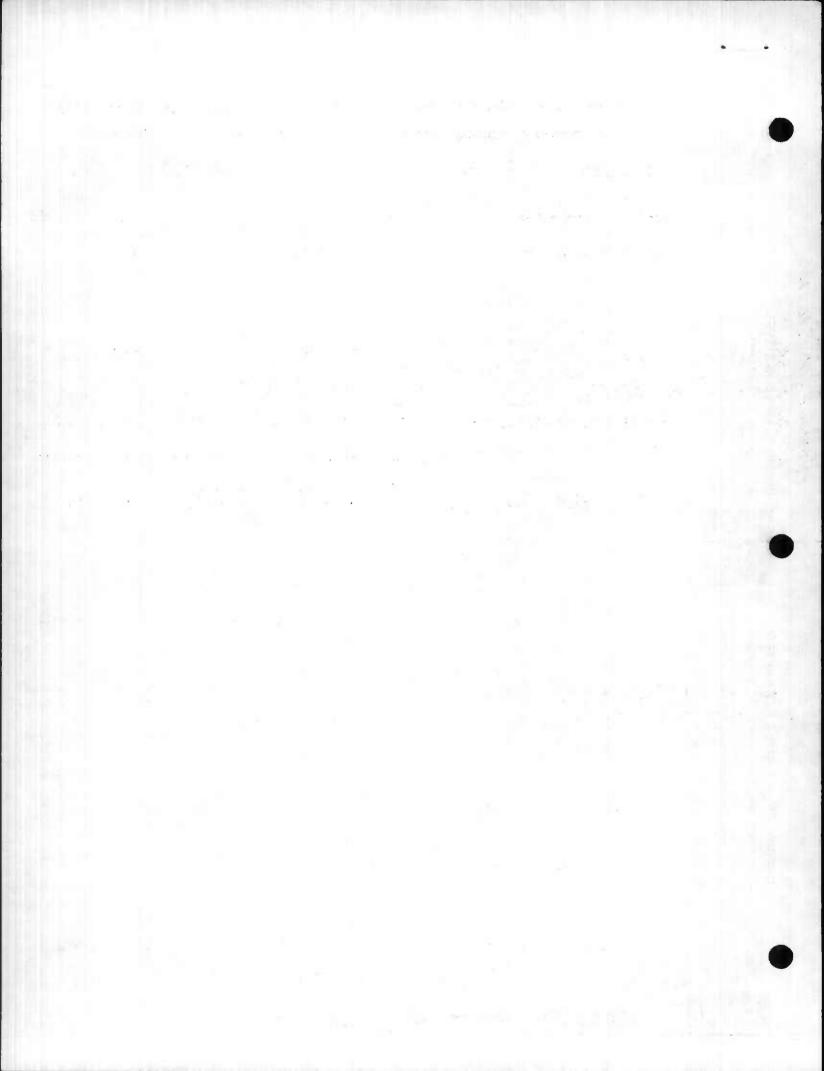
Ay ATUM (1) O Y Western Ine Solis on 21804 Atlans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 29 1998

HARLOTTE



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Veer Kathleen P. McKenzie December 21, 1998 6:50 A.M. 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Garrett 135 McKenzie Road Lonaconing If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) if Under 1 Year 1 M 2 F Months Days 214-52-2051 Usuel Residence of Decedent December 19,1916 Maryland 82 10e State 10d inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☑ No Lonaconing Maryland Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21539 USA 135 McKenzie Road 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 12. Wes Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican indian, 11. Maritai Status Black, Whita, atc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No 1 Yas 2 XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Rose Robeson Charles Dishong 19e, Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 135 McKenzie Road, Lonaconing, MD 21539 Howard I. McKenzie/Husband 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) St. Ann's Cemetery, Dec.23, 1998 Avilton, MD 21. Signature of Funeral Service Licensee 22. Nama end Address of Fecility Newman Funeral Homes, P.A. Q 179 Miller St., PO Box 275, Grantsville, MD 21536 23e. Pert1. Enter the diveese, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or hall a failure. List only one cause on each line. Approximate Interval Between Onsat and Deeth immediate Cause (Final disease or condition resulting in death) hemia ancuto Denia Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in daeth) Lest Due to (or es e consequence of Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? TE Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumants.

Baltimore, Maryland 21215-0020

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death

Examiner Physician/Medical P Completed Be 9

buriel-transit and attending physician the use as 0 2 signed b peeu page 2 has director, funeral Certification:

that the death certificete be exec the bed certificate Attending Physician: this After \* hours after death.

\*I Director: A\*

\*I Director: A\*

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Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 hor To the Fune completely fi Medical 2 2060

29a. Certifier

31. Deta filed (Month, Dey, Yeer)

DEC 2 9 1998

State Registrar Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending invastigation 1 Neturei 1 Tyes 2 🗆 No 2 ☐ Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

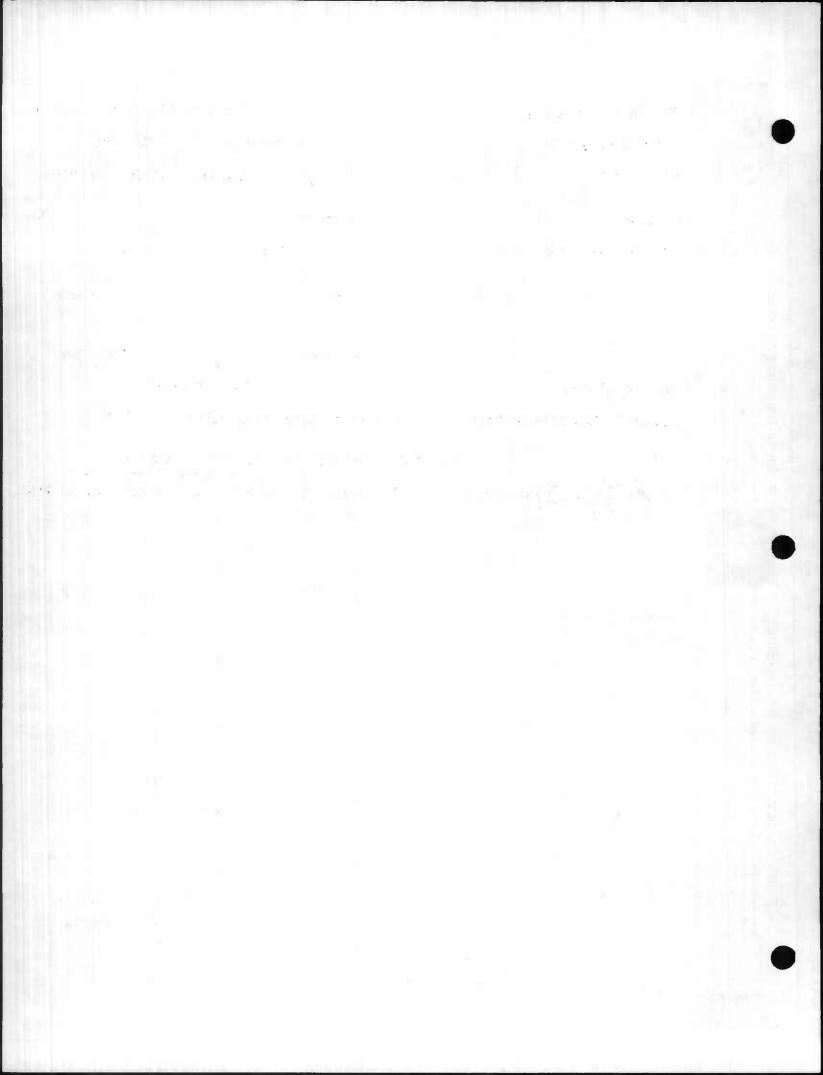
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier

ava

30. Neme end eddress of person who completed auto o deeth (item 23e) (Type, Print)

990

32. Ragistrer's Signeture



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21215-0020 d within 72 hours efter death with the Maryland	jene. r than "natural", or items 23a or 28a-f ehow Tra Medical Exansiner must be notified at	by	11. Merital Stetus  1 Never Merrled 2 Married  3 Widowed 4 Divorced	12. Was Decedan Armed Forces 1  Yas 2 If Yes, Give Yeer or Detas	? No	J,S. 13.		edent of I ecify Cub 2 19 No	dispanto Origin? ( an, Mexicen, Pue Specify:	Specify Yes or Norto Ricen, etc.)		ce - Amaric ock, White, White	etc.
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Baltimore,	Department of Health Important: If item 27 any injury or other tr pince.		1 Burial 2 □ Crametion 3 4 □ Donetion 5 □ Other (Spec		9	cematary, cre	metory or	other ple		7-Dec-98	Frostburg		
Balt permit.	Import any in		21. Signatura of Funarel Service Lice	ensee	11				ss of Facility Home, 57	Frost Ave.,	Frostbura	MD 2	1532
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Attending P	: After t e funera	ation:	27. Menner of Deeth Neturei 5 Panding 2 Accident Investigeti	28e. Deta of Inj (Month, D	ury ey Y <i>ear)</i>	28b. Time o Injury	f M	28c. Injur Wor	yet k? Yes 2 ∐ No	28d. Describe	how Injury occu	rred	
DIVISION lal or Attending	s effer death.  In Director: After the of in by the funera	Certification:	3 Suicida 6 Couid not determine	28e. Plece of Ir building, e	njury - At h rtc. (Speci	ome, ferm, st	reet, facto	ry, office		28f. Location ( City or To	Street and Num wn, Steta)	ber or Rura	I Routa Number,
Hospital	Virnin 24 nours end To the Funeral Dir completely filled in	edical	29a. Certifier Check only one) Certifying P	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the	Toth	Me	29b. Signeture and title of certifier				25	9c. Licens	e number		29d. Dete signe	ed (Month,	Day, Year)
	4		I HE Me	rush	•			D	2891	0	Dec.	28	3,1998
	nes		30. Name end eddress of person who H. Curtis Merrick, 5					nd, Mo	aryland 21	502			
	Sta Registr	te	31. Dete filed (Month, Day, Year) DEC 2 8 199	8 32. Aegist	trar's Signi	eture	R	2.11					

L-cember 23 1998 08:20 AM Norma Jean Miller Allegany Klondike 20503 Klondike Road, S.W. 18-May-28 Maryland 70 213-24-5803 Allegany Frostburg Maryland 20503 Klondike Road, S.W. U.S.A. 21532-White Homemaker Homemaker 12 William Yantz Alberta Schell son 20503 Klondike Road, S.W. Frostburg Maryland 21532-Dale Miller Frostburg Memorial Park 27-Dec-98 Frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 410pm ELMER MOTHERSHEAD 1998 DEC 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE ( COUTHERN MARYLAND HOSPITCAL CENTER CLINTON If Under 24 Hrs. If Under 1 Yaar Months Days Birthplace (State or Foraign Country) 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1 M 2 □ F Days Hours 94 March 19, 578 05 2334 1904 WashingtonDC Usual Rasidence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD P.G. Forestville 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7502 Marion Street United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 X No If Yes, Giva 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: White ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bakery Industry Confectionary Worker 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) William Mothershead Betty Coats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 4175 Fox Run Lane, Huntingtown, Maryland 20639 Ellen Suthard (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 157 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery Dec 21, 1998 Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Error the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hoc heart failure. List only one cause on as brine. Interval Between Onsat and Death Immediata Causa (Final RENAL FAILURE 4 DAY diseasa or condition resulting in death) Due to (or as a consequence of): METASTATIC PROGTATE CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TE Yes 25 No 1 Yes 2KINO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Naturat 2 Accident 1 Yes 2 No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner Box 68760. Records, P.O.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

Completed by

Be

Certification: To

edical

(Check only one)

29b. Signature and titla of certifier

31. Data filed (Month, Day, Year)

**Funeral** 

Director

r than "natural", or items 23s or 28s-f ahor the Medical Exeminer must be notified at

the Maryland

death with

filed within 72 hours after

i. Pages 1 and 2 should be filed within 7 timent of Health and Mental Hygiene. Hant: If Itam 27 Ia marked other than "n ijury or other traumatic avent, the Heal

permit. Page Department of Important: If any Injury or pages.

**Physician** /Medical

physician and the burial-transit

USB 88

signed by the a

page 2

certificate

this

Affer

filled in by

21215-0020

Baltimore, Maryland

The law requires that the death certificate be axecuted Division of Vital or Attanding Physician: 24 hours after death.

Funeral Director: Al Hospital

within 2 \$

> State Registrar

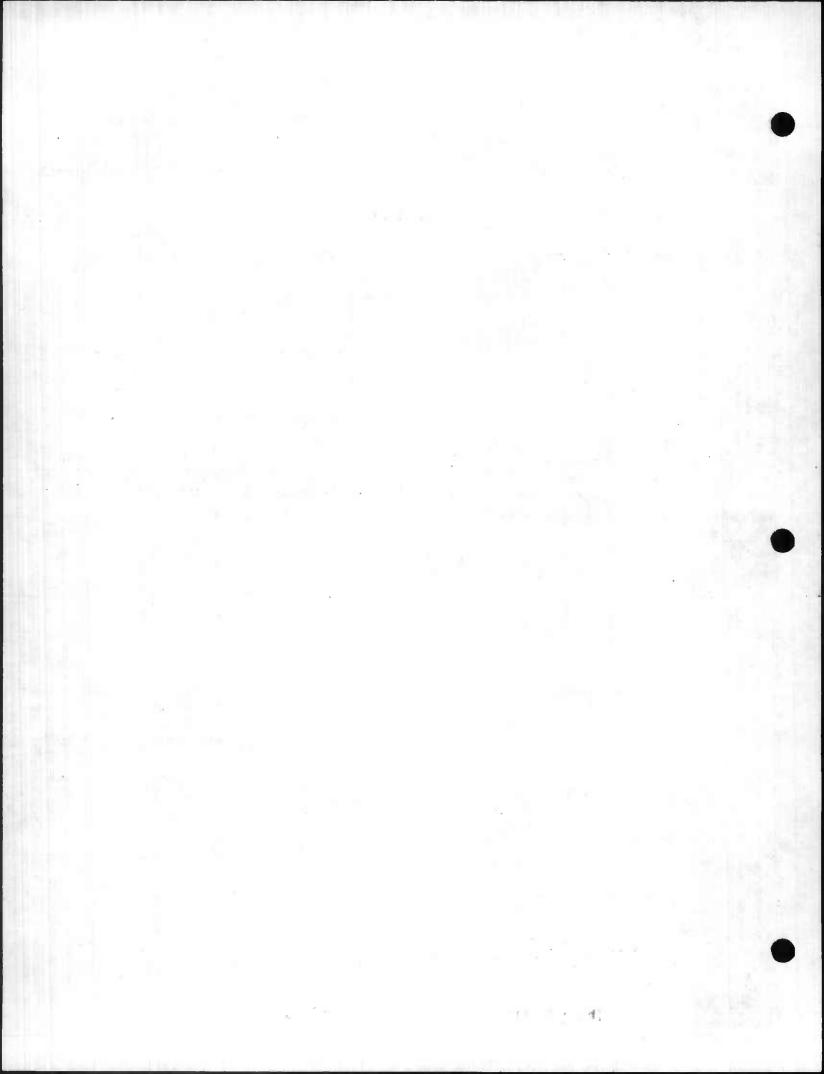
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) VINCENT CHEN, MY

9131 PISCATAWAY RO #600 CLINTON INS 20735 32. Registrar's Signature DEC 2 2 1998 >

29c. License number

29d. Date signed (Month, Day, Year)

DEC 18 1998



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Vaar ANNA ESTELLE MC COLLEY DECEMBER 18,1998 5:15 AM 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital eonardtown If Under 24 Hrs. 8. D ST. MARY"S 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In vrs. last birthday) Birthpiaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Months 1□M 2√2 F Days Hours Min 579 22 3579 101 Yrs. Dec 10, 1897 Maryland Usual Rasidance of Decadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas XX No Mechanicsville St. Mary's 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? United States 28625 Hancock Drive 20659 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 11 Marital Status 13. Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 1 Navar Married 2 Married 1□ Yas 2□ No Specify Specify: White 3€ Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Clerk Printers 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) William Edward Johnson Mary E. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) James W. Barry, Sr. (SON IN LAW) 28625 Hancock Drive, Mechanicsville, MD 20659 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Dec 23, 1998 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from State Arlington National Cemetery 4 ☐ Donation 5, ☐ Other (Specify) Arlington , Virginia 21. Signatura of Furiaral Sarvica Licensaa 22. Nama and Addrass of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Oriset and Peath immediata Causa (Final disaasa or condition rasulting in daath) Athero solussi Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death4 1 Yes 2 No 3 Probably 4 Onknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2FINO 1 🗆 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 1 ☐ inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 []Natural 5 Panding invastigation injury 1 Yas 2 No 2 Accident 6 Could not be datarmined

Examiner The law requires that the death certificate be executed this

**Physician** 

/Medicai

Examiner

**Funeral** 

Director

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the Medical Examiner must be notified at

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Physician/Medical Examiner

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29b.

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Monatura and titla of certifie

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death

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Peges 1 end 2 should be filed within nent of Health end Mentel Hygiene. int: If item 27 is marked other than?

other traumatic

permit. Peges 1 and 2 a Department of Health or Important: If item 27 is any injury or other trau once.

Physician /Medicai

altimore. Maryland 21215-0020

physician end the burial-trans Box 68760. use a for u P.O. signed b Records, page 2 should of Vital or Attending Physician: After Division 24 hours efter death. filled in by Hospital within 2 To the \$

State

Registrar

of parson who compla 30. Nama and addre 31. Data filed (Month, Day, Year)
DEC 2 32. Registrar's Signatura

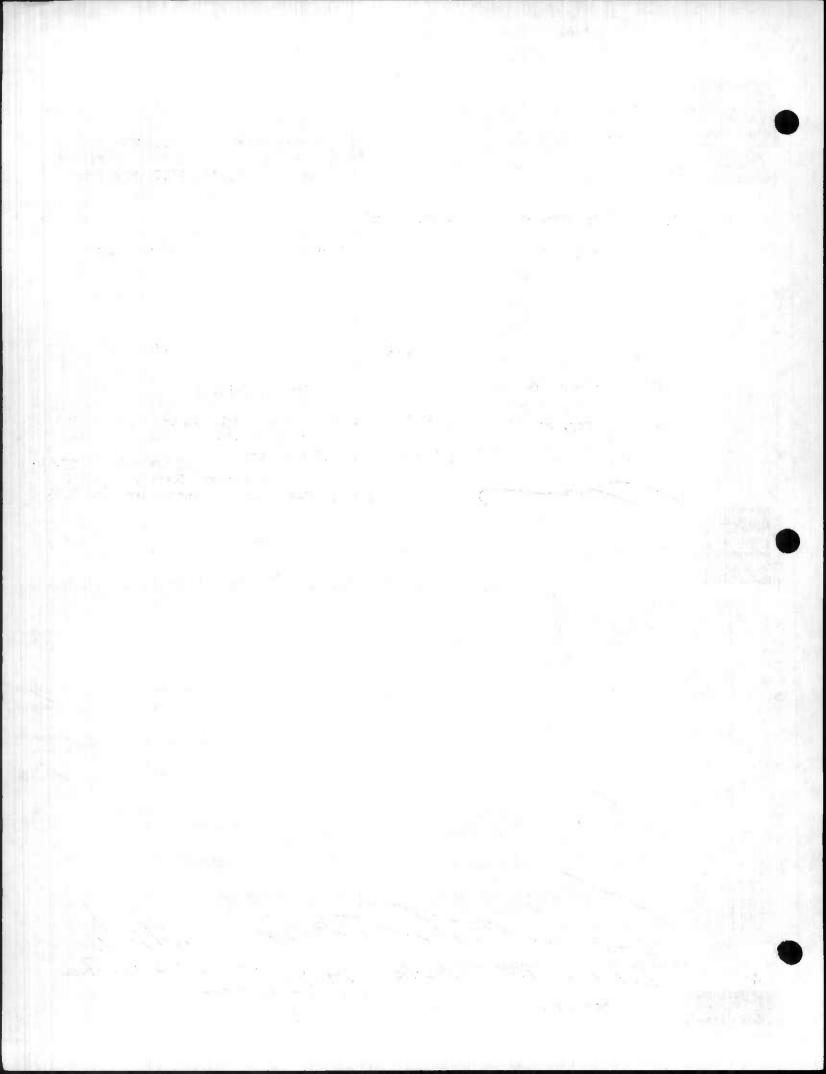
Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

estigation, in my opinion, death occurred at the time, date and place, end due to the gause(s)



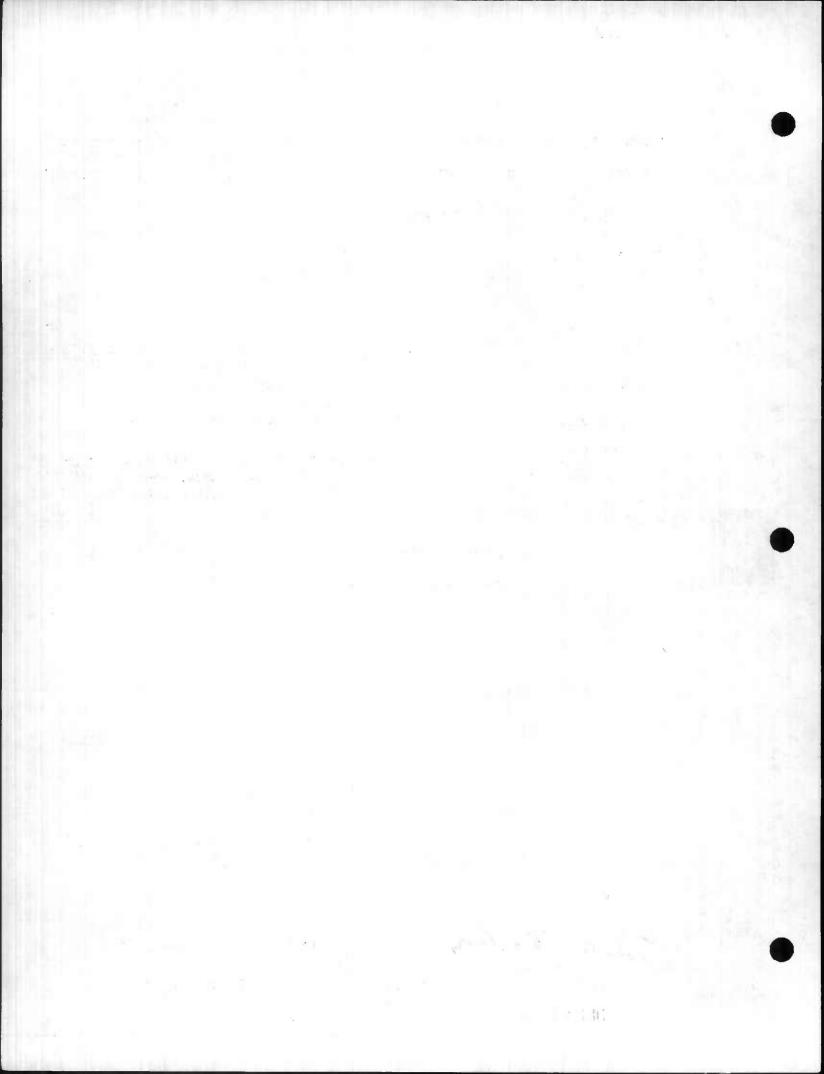
Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** Thomas Masano 7:55 A.M. Dec 10. 1998 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hosptial Clinton If Under 24 Hrs Prince George's 8. Date of Birth (Month, Day, Year) 6. Sex 1X M 2□ F If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours **Director** 579 38 2798 68 Jan 1, 1930 West Virginia Usual Residence of Decedent with the Maryland 10a. Stata 10b. Counts 10c. City, Town or Location 10d. Inside City Limits raf, or items 23s or 28s-f show Examiner must be notified at MD 1 Yes 2 No Director P.G. Clinton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7702 Don Drive 20735 death United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours aftar 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ tho Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **Employed** Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mertal hygient Important: If fam 27 is marked other that any fujury or other traumatic avant, that Date. 12 Artistan Woodworking / Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Comedo Masano Angelina Brugulio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marlene Masano 7702 Don Drive, Clinton, Maryland 20735 20a. Method of Disposition
1 ☐ Burial 2 Gremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Dec 13, 1998 Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final ARRIGITHMIA disease or condition resulting in death) Examiner Due to (or as a consequence of): CANSIOMIJOPATT Ly Examiner iclan and burial-transit that the death certificate be assouted Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical Due to (or as a consequence of): signed by the at d be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 ☐ Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 86 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospifal: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending death. 1 Tyes 2 No investigation 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 15d Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely f (Check only one) within 2 ş 29b. Signature and title of certilier 29c. License number 29d. Date signed (Month, Day, Year) osult D 1261 Dec 12, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Kenneth T., Larsen, Jr. 7503 Surratts Road, EM Dept, Clinton, Maryland 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

DEC 2 2 1998



F	ODERICK ITEM	A. MATHIS : #23 PART I, 27  1. Decedent's Name (First, Middle,	7, 28A-F PE	-	epartment of Certificate of			eg. No.	3. Time of Death	
	Physician	RODERICK A.	MATHIS				Month DEC.	28, 1998	1815 PM	
	/Medica Examinei	4e Facility Name (If not institution, give street and number) 16002 EASTINGS COURT-B				4b. City, Town, or L BOWIE		4c. County of De		
e, Marylan	Funeral Director	5. Social Security Number  579-82-1650  Capable 1			Months Dey					
	filed within 72 hours effer death with the Maryland Vigorea. Outurel, or flems 23a or 28a-f show ent, the Markel Examiner must be notified at a Completed by Funeral Director	10a. State     10b. County     10c. City, Town or Location     10d. Inside City Limits       Maryland     Prince George's     Bowie     1X Yas 2□ No								
		100. Street and Number 16002 Eastings Court, Apt #B			10f. Zip Code 20716			10g. Citizen of What Country? U.S.A.		
		3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' d 1 🔀 Yes 2 🗌 If Yes, Give Year or Dates:	No U4/ 1904	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of the Yes, specify Cuben, Mexican, Puerto Rican, etc.)</li> <li>Yes 2 No Specify:</li> </ol>		pecify Yes or No- p Rican, etc.)	14. Rece - American Indian, Black, White, etc. Specify: Black		
		15. Decedents (Specify only highest Elementary/Secondary (0-12)	p. Decedent's Education only highest grade completed) any (0-12) College (1-4or 5+)		ia. Decedent's Usuel Occupation (Give kind of work done during most of workin life. DO NOT use retired)  Office Assistant		king	16b. Kind of Business/Industry  Private		
	S T S C	17. Father's Name (First, Middle, Last) Albert R. Mathis					ne (First, Middle, I	faiden Sumame)		
	2 9 9 9	19a. Informant's Name/Relationshi	1 1 00740							
	2 2 2 2	20a. Method of Disposition  10 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Harmony Memorial Park  20c. Location - City or Town, Stete  01/04  Landover, Maryland								
Balt	permit. Pag Department Important: h any injury o once.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  J. B. JENKINS FUNERAL HOME  7474 Landover Road, Landover, Maryland 20785								
	hysician /Medical	23a. Part1. Enter the see, or c shock, or heart failure. List or immediate Cause (Finat	omplicationa that cause nly one cause on each t	d the death. Do not ine.					Approximate the triterval Between Onset and Deeth	
ords, P.O. Box 68760,	pe examiner properties and propertie	disease or condition resulting in death)	a FOCAL	MYCOCARDI Due to (or as a cor	AL FIRROS:	IS COMPLIC	ATED BY	COCAINE A	BUSE	
			b	Due to (or as a cor	nsequence of):				1	
	the the	Cause (Disease or Injury that initiated events resulting in death) Last	d	c Due to (or as a consequence of): d						
	detached for u	Part II. Other significant condition	s contributing to death b	ting to death but not resulting In the underlying cause given in Pert I.				23b. Did tobacco usa contributa to the cause of death?  1 Yea 2 No 3 Probably 4 Unknown		
	as been sign 2 should be		20				24a. Wes a perior		b. Were autopsy findings available prior to completion of cause of death?	
	ate has page 2						1184	8 2 No	1 Yes 2 No	
Vital	to the second	25. Was case referred to medical examiner?	Hospital.	26. Place of Death (Check only one)  Hospital: 4 Theories 27 Total Other: 4						
ō	th. After this certure of funeral directions. To E	1 Netural 5 Pending 2 Accident Investigation	28a. Date of trip (Month, Date)	28a. Date of Injury (Month, Day Year)   Found:   Musing Home   28b. Time of Injury   P   10   Yes 2   10   Ye			28d. Describe h	ne SXXResidence 6 □Other (Specify)  18d. Describe how injury occurred  UNKNOWN		
	after death. Director: After i in by the funer.	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	<u>-98   3:</u>	, street, factory, offic		28f. Location /S	reet and Number or	Rural Route Number, EASTINGS CT	

To the Hospital or Attending Physician: The law requires in within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be

Completed by Be Medical Certification: To

29e. Certifier (Check only one)

FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State) 16002 EASTINGS BOWIE, MARYLAND 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner as stated.

2X Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certified

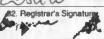
29c. License number O.C.M.E 29d. Dete aigned (Month, Day, Year) DEC. 29, 1998

ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp

111 Penn Street, Baltimore, Maryland 21201 MUDNOD who

31. Data filed (Month, Day, Year)

JAN 0 4 1999





State

Registrar

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JAN 64 BUS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ITEMS: #17, 19B PER INFORMANT G769 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend # 2. Per Phys. PGC 12-21-98 cr 1. Decedant's Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death Day Month 13 **Physician** MANUS 5:55 AM LaVONNE Dec 1998 100 /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Beltsville Prince George's 13125 Greenmount Avenue If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foraign Country) 7. Aga (in yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 X E 578-50-9215 Yrs. 61 September 6,1937 Washington, D.C. Director Usual Residence of Decedant with the Maryland 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "naturel", or items 23s or 28s-f ehow ary or other traumetic event, the Medical Examine must be notified as 10a Stafa 10b. County 10d. Insida City Limite 1X Yes 2 No Prince George's Beltsville Maryland Directo 10g. Citizan of What Country? 10e. Streef and Number 10f. Zip Code 20705 U.S.A. 13125 Greenmount Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whifa, efc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 11. Merifel Stafus 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 Specify: Black 1 TYas 2 No Specify: à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) Elementery/Secondary (0-12) Collage (1-4or 5+) Private Financial Specialist 2 years 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maldan Sumeme) Be Margaret Lyles Oscar McDaniels 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8910 Trepper Court, Adelphi, Maryland 20783 Ursula Epps/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1998 21 Signefura of Funarai Sarvice I Icansee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Marylannd 20785 Perc Vancu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failures at only one cause on each line. Approximete Intarval Between Onsaf and Death **Physician** Immediate Causa (Final disaasa or condition rasulting in daath) /Medical METASTATIC ROM CARCINONA 12 ms. Examiner Dua to (or as e consequance of) Examiner physician and s the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Causa (Disease or Injury thaf Initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua fo (or as e consaquance of): attending pl signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ been si 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed completion of cause of death? certificate has b lirector, page 2 s 2 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Homa See Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding Investigation 1 Netural 1 Yes 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dil completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number mo

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State Registrar

30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print)

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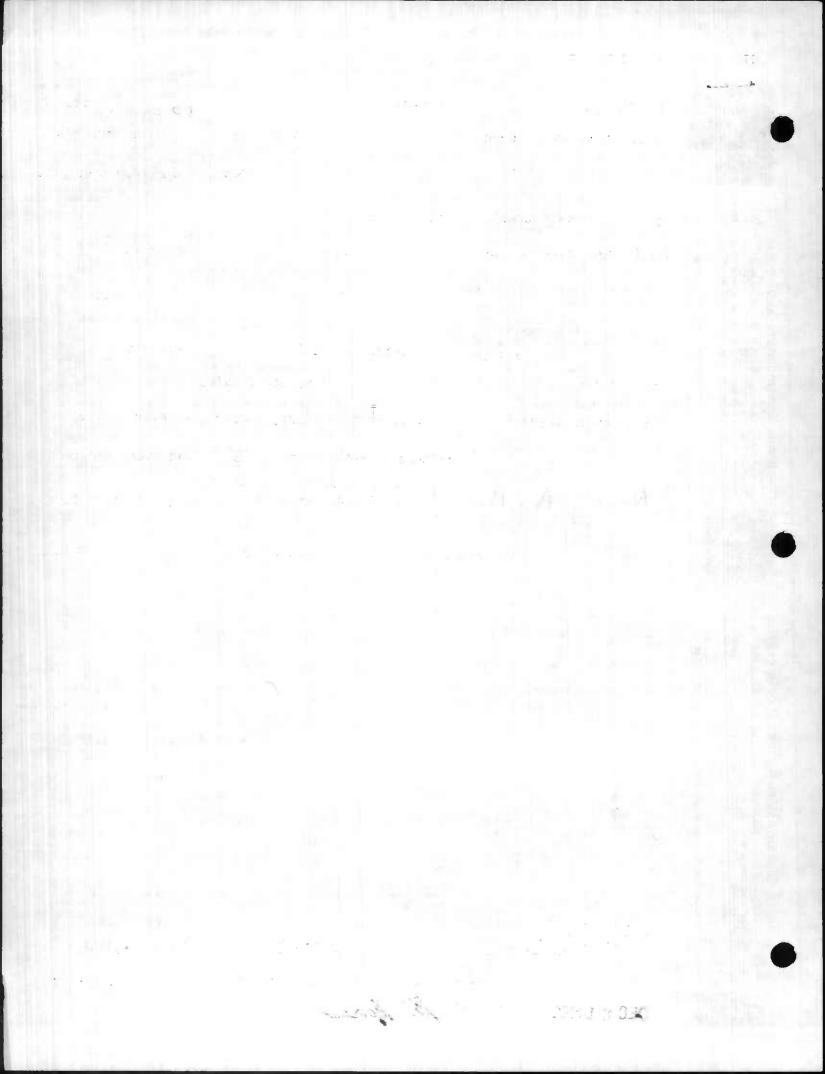
32. Registrar's Signature

- MRD

DEC 2 1 1998

31. Date filad (Month, Day, Yaar)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Physician DECEMBER 15, 1998 LUCY BRUMFIELD McDUFFIE 8:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY COUNTY If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Months Director 578-28-9051 JAN. 19, 1926 MARYLAND Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND PRINCE GEORGE'S GLENARDEN the th 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7932 GLENARDEN PARKWAY, #423 20706 UNITED STATES deeth 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours effer Hygiene. Ther then "netural", or its 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK P 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK FEDERAL GOVERNMENT 12 permit. Pages 1 and 2 should be file Department of Hesith and Mantal Hy Important: If Nem 27 is marked othe eny Injury or other treumatic event, pages. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 2 REUBEN BRUMFIELD AGNES MEYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE R. McDUFFIE, III, SON 10509 THRIFT ROAD, CLINTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 12/21/98 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Dreumonia Examiner Examiner acci des erebrovusivlar physician and the buriel-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 edical Due to (or as a consequ Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? o 1 Yea 2 No 3 Probably 4 Unknown ۵ been signed beneares +45 Ciitis Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed ulcer 24a. Wes an autopsy decubitus nellitus Ě diabetes 1 Yes 2 No 1 Tes 2 No certificate Division of Vital Hospital or Attending Physicien: 24 hours after deeth. Funeral Director: After this certifical stely filled in by the funeral director, i 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 Yes 2 1 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Cortrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

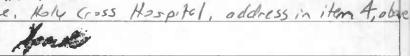
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Kaiser Office, Roy Fried .M) Registrar's Signeture

res 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Funeral			Sex 7. A		lest birthde. Yrs.	y) If Undar Months	1 Yaar Deys	If Undar Hours	Min.	8. Date of Bir (Month, De	th Year) 1964	9. Birthple Count	ca (Stete	or Foreign
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a	nd 2 should be filed within 72 halfs and Mentai Hygiene. 27 is marked other than "nature fraumatic event, the Medical		19a. Informant's Name/Relationship	(Type, Print)		19b. Me	lling Address	(Street	and Numbe	er or Run	al Route Numb	er, City or Town,	State, Zip (	Code)	
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pallillore,	permit. Pages 1 and Department of Heali important: If Item 2 any injury or other other.		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  20b. Pleca of Disposition (Nema of cematery, cramafory or other place)  20c. 22							.22,	1998	20c. Location -	City or Tow	m, Steta	
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0	epan mpon ny in		21. Signature of for rel Service Licensee 22. Nama and Addrass of Facility Robert G. Mason Funeral Home, In											ne, Inc	
	20280		1661 Good Hope Road, S.E.; Washington, D.C. 20020												020
	Physician /Medical Examiner		23e. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heert teliura. List only one cause on each line.  Immediate Ceuse (Finel disease or condition resulting in death)  Right Heart Congestive Heart Failure  Due to (or as a consequence of): Morbid Exogenous Obesity												
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	ate be axecuted hysician and the burial-transit	Examine	b. Due to (or as a consequence of):												
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	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director After this completely filled in by the funeral di	edical	29e. Certifier 1 Certifying P (Check only one) 2 Medical Exs	Physician: To the best aminer: On the besis of	of examine	owiedga, dea etion end/or	ith occurred of Invastigation,	et the tin	ne, dete an pinion, dee	d plece, th occurr	and due to tha ed et the time,	cause(a) and ma data and place,	anner as ata and due to	ted. the cause	(s)
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Marine A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month HASSIE BELL MCDANIEL December 19,1998 10:35PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Doctor's Hospital Lanham Prince Georges If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 M 2 CXF 578-84-2852 89 Yrs. Director Nov 30,1909South Carolina Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD PG Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5416 Ruxton Drive 20706 U.S.A. items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes & No If Yes, Give Yeer or Detes: ŏ 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Domestic Engineer Pvt. Families 6th 17. Fether's Neme (First, Middle, Last) Pages 1 end 2 should be file ment of Health and Mentel Hy ant: If Itam 27 Is marked oth 18. Mother's Name (First, Middle, Meiden Surname) John Dixon Frances (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2: Department of Health at Important: If Itam 27 is eny injury or other tracence. Mary F. Minor - Daughter 5416 Ruxton Drive, Lanham, MD 20706 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 12/26/98 Suitland, MD 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility Marshall's Funeral Home, Inc. 23e. Pebr. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximete Intervel Between Onset and Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) Atherosclerotic Cardiovascular /Medicai Examiner Due to (or es e consequenca of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest and Due to (or es e consequença of) ettending physician for use es the burle Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 | Yee 2 No 3 | Probably 4 | Unknown Cerebrovoscular Disease þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? this certificate 1 Yes 2 PNo Division of Vital Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Certification: To 1☐ Yes 2☐ No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Neturel 1 TYes 2 □ No 2 Accident filled in by the 6 Couid not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. Medicai 29a. Certifier To the Host within 24 ho To the Fune completely fi 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 039550

4850 Forbes Blud Lanham, md 20706

Registrar

State

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

George C.

31. Dete filed (Month, Day, Year)

DEC 2 3 1998

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32. Registrer's Signature

DHMH 16 Rav 6/95

Secretary of the second

Plcase Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Dete of Deeth 3. Tima of Death Month 12 13 - 98 9:30 am MAXINE E. MILTON 4a Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth 833 English Chestnut Ct. Prince George's Landover, Md. If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Days Hours 1 DM 2 F Yrs. 577-54-1703 59 02 - 01 - 39Maryland Usuel Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits X☐ Yes 2☐ No Md. Prince George's Landover 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Coda 20785 USA 833 English Chestunut Ct. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ② ONo If Yes, Give Year or Detas: Was Decedent of Hispanic Orlgln? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S. Postal Service 12th Mail Clerk 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Elease McDaniel Jessie Milton 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 20785 19e. Informent's Neme/Raletionship (Type, Print) 833 English Chestnut Ct., Landover, Md. Makesia Milton, Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition YOSurial 2 □ Crametion 3 □ Removel from Steta 4 □ Doyalion 5 □ Other (Specify) 12-17-98 Harmony Mem. Park Landover, Md. 21. Sign. u.e of Funaral Service Licenses Ralph Williams Funeral Service 20003 517 11th St., S.E., Wash., DC Ta. Pert1. Enter the riseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feiture. List only one cause on each line. ulleun Approximete Intervel Between Onset and Deeth Hest Cince Immediete Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events rasulting in death) Lest Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee ZONo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2000 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 sh Department of Health and Important: if itsm 27 is m any injury or other traum once.

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

P

**Funeral** 

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic avent, the Medical Examinal must be notified at

2 should be filed within 72 hours efter death v and Mental Hygiene. Is marked other than "natural", or itama 22s

Baltimore, Maryland 21215-0020

with the Maryland

ettending physician and for use es the buriel-transit 29 esn detached Pg. á signed t peeu hes page 2 certificate this After

that the death certificate be executed

Box 68760

Division of Vital Records,

or Attending

Hospital 24 hours

within 2 the

3

edical

Examiner Physician/Medical by Completed Be 1º funeral Certification: efter deeth.

29e. Cartifier

(Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2X No 27. Manger of Deeth 1 Naturel

5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and plannar stated. 29b. Signeture and title of certifie

28a. Date of Injury (Month, Dey Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Plece of Injury - At home, ferm, straet, fectory, office building, etc. (Specify)

28b. Tima of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

1 □ Yes 2 □ No

29d. Dete signed (Month, Pay/Year)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete)

Other: 4 Nursing Home Residence 6 Other (Specify)

28d. Dascribe how injury occurred

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Hospital:

Staal, 1221 Mercantile Lane, Largo, Md. 20785 Stephen P. M.D.,

State Registrar

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I product at the State

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O

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or 28	Director	10e. Street and Numbar					10f. Zip (	Coda			10	g. Citizan of	What Count	ry?	
23a		12414 PINE	TREE	ROAD, S.	Ε		215	02				U.S.A	١		
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To the Funeral Director: After th completely filled in by the funeral	edicai	CONTROL ONLY	ertifying Phy ledical Exami	nar: Un the besis	of axamina	wladge, death tion and/or Inva	occurred at stigation, In	tha tim	ea, data and piac pinion, daath occ	e, and urred a	dua to tha cau t tha tima, dat	usa(s) and ma a and place,	nnar as stat	ted. he cause(s)	
omple omple	-	4a. Facility Nama (If not institution, giva street and number)  CUMBERLAND NURSING HOME  5. Social Sacurity Number 212-24-1846  Usual Residence of Dacadant  10a. Stata 10b. County MD ALLEGANY  10c. Street and Number  12414 PINE TREE ROAD, S.E. 11. Marital Status 11 Nevar Marriad Marriad Marriad Sulvidowed 4 Divorced Specify only highast grada completed)  Elemantary/Secondary (0-12) 9  17. Father's Nama (First, Middla, Last)  EDGAR W. SEE  19a. Informant's Name/Reletionship (Type, Print)  FRANKLIN J. NIXON / HUSBAND  20a. Method of Disposition 1 Sporial 2 Deramation 3 Ramoval from Stata 4 Donation 5 Dhar (Specify)  21. Signature of Funaral Service Licensee  12. Was Dacodent Evar in U. Armoder Forest State A Donation 5 Davidowed Stat													
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23	-	20 Name Jeler	Du	MU)	1			770	1		L	CCEMBE	K 28,	1998	
		JU. Name and address of	Derson Who co	omplated causa of	geath (Itag	2301 /Tune D	mtm A 3								
6															

South of Garleet

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Virginia Mae Orndoff Dec. 23, 1998 8:00 am 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath 678 Fayette Street Cumberland Allegany 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 1□ M 2X F Months Days Hours Yrs. 233-34-7301 75 Mar 17, MD Usual Rasidanca of Dacadan 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Cumberland Allegany 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 678 Fayette Street 21502 USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Biack, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify 3X Widowad 4 ☐ Divorced white 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Coilega (1-4or 5+) 12 Cosmetologist Dept. Store 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Thomas B. Jones Anna May (Miller) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Richard C. Orndoff-son 16309 Brice Hollow Road SE Cumberland MD 21502 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Veterans Cem 12/24 Flintstone MD 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Address of Facility Scarpelli Funeral Home, P.A. 23a. Parti. Entar tha disaasa, or complications the causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart tailura. List only one causa on aach lina. Approximata Intarval Batween Onset and Death Immediata Causa (Finai Year? diseasa or condition rasulting in daath) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Dua to (or as a consequence of) Causa (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Obstructive Pulnonary disease 24b. Wara autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy 1□ Yas 2□No 1 TYas 2 No 28. Placa of Death (Check only ona)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stata

MD

Director

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or frems 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within Department of Heelth and Mental hygiene. Important: If Item 27 is marked other than "reany injury or other traumatic event, the Med

the Maryland

with

death

72 hours efter

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

Examiner physician and the buriel-transit Physician/Medical by Completed Be Medical Certification: To

ed by the a signed b peeu page 2 has certificate After thi funeral To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral process. or Attending

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25. Was casa ratarred to medical axaminar? Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturel 5 Panding Invastigation 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, farm, streat, factory, office building, afc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29e. Certifiar (Check only one) Certifying Physician: To tha best of my knowledga, death occurred at tha tima, date end plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and due to the causa(s) and manner stated. 29b. Signatura and titia of certifia 29c. Licansa number 29d. Data signed (Month, Day, Year)

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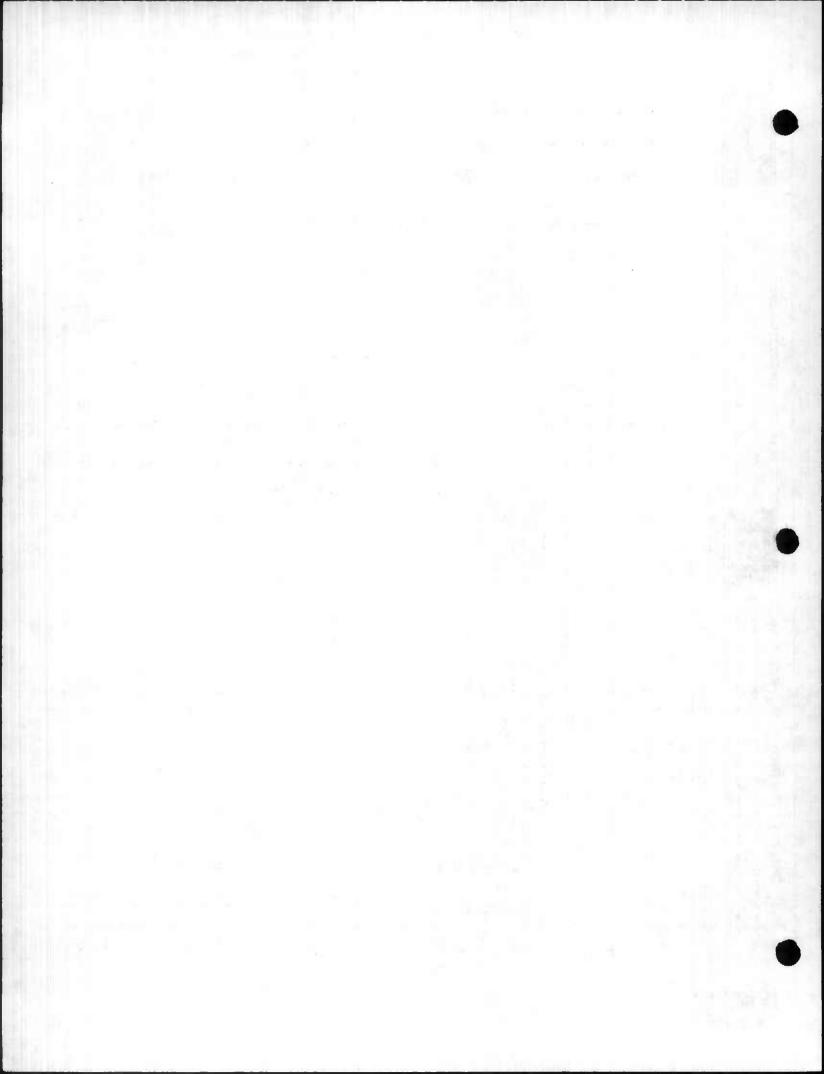
Dec 23, 1998

30. Nama and address of parson who complated causa of death (Itam 23a) (Type, Print)

Dr. Sunil Gupta; 625 Kent Avenue; Cumberland, MD 21502

State Registrar 31. Data filed (Month, Day, Year) **DEC 23**  32. Registrar's Signatura Dener

D33280



State Registrar

DEC 3 1 1998

32. Registrer'a Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3 Time of Death **Physician** Tse po ARKEY ARNE 800 1998 /Medical 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death BIEN BURNIE HUndar 24 Hrs. 8. Dan-Hours Min. 8. Dan-4c. County of Deeth Examiner Arundel 7. Aga (In yrs. les birthday) Colev 6. Sax 12 M 2□ F If Under 1 Year 8. Data of Birth (Month, Dey, 5. Social Sacurity Number Birthplace (State or Foreign Country) **Funeral** Months Deys 252-66-99 Usual Residence of Dece Director WAShington TACOMA. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits EAST LANSdowNe Delaware Director 1 Yes 2 No 10e. Street and Numbar 10g. Citizen of Whet Country? Evanior must be 19050 States United Funerai 12. Was Decadant Evar in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 Never Merried 2 Married 1 ☐ Yas 2 No If Yes, Giva Specify: Black 1 Yes 2 No þ if Yes, Giva Year or Datas: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) Coilege (1-4or 5+) Student Elem, Schoo 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Parkion Wesley 10 mokemane INEO 19a. Informant's N me/Relationship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Route Number, City or Town, State, Zip Code) 73 EAST CANSdown. 20c. Location - City or Town, State wesley wesley parker 20a. Method of Disposition Father HIRST 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) = 6 important: If any injury o Cem. 1-2-99 Feerwood FRENWOOd FUNCTED 22. Nama and Addrass of Facility WHARTEN Whateon 22171 Wharton Rd Accompa, UA. 23361 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immediate Cause (Finel diseasa or condition resulting in death) /Medical INSTANT Examiner Examiner ician and bunal-transit Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of) physician s the bunal Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) 65 USB Pert II. Other significant conditions contributing to death but not rasuiting in the underlying causa givan in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was en eutopsy performed? page 2 1 Yas 2 000 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner?
1 X Yes 2 □ No Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 XER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending investigation Chicle Collision 2 Accident 1645M 1 Yes 2 No 17-26-48 6 ☐ Could not be 28e. Piece of Injury - At home, term, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760. ne Hospital or Attending Pl n 24 hours after deeth.

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23.

permit. Page Department of

Baltimore, Maryland 21215-0020

28a-f 1

10 Registrar

Medical

29a. Certifier

(Check only one)

29b. Signatura and titla of certifian

end address of person who completed cause of deeth (Item 23a) (Type, Print) ONCS, MO 32. Registrer's Signeture

Deputy

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

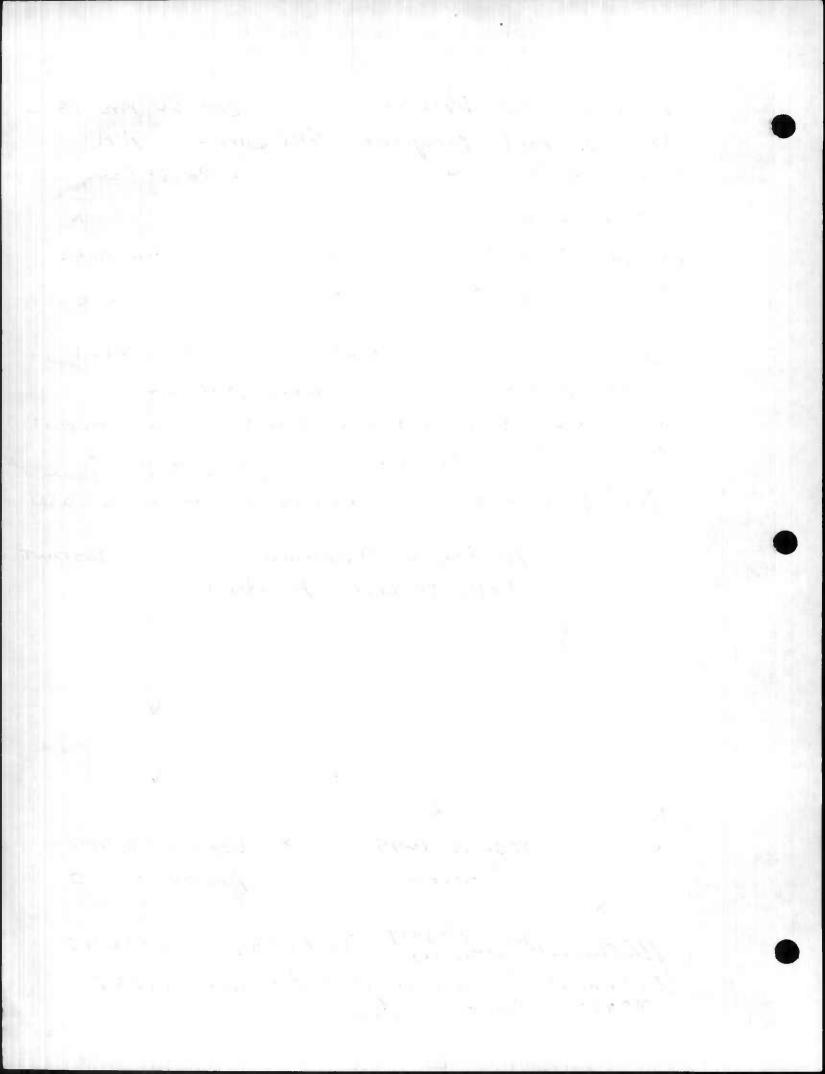
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29c. License number

06054

HANOVEY,

29d. Dete signed (Month, Day, Year)



26. Place of Death (Check only one)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Deta signed (Month, Day, Year)

1 Yas 2 No

YRS

YRS

**Funeral** Director

**Physician** 

/Medical

Examiner

Mary

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at d 2 should be filed within 72 th and Mentel Hyglene.
7 Is marked other than "ne permit. Pages 1 end 2 st Department of Health and Important: if item 27 is n eny injury or other traun

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

Examiner ettending physician and for use as the burial-transit Physician/Medical signed by the elid be detached for by Completed peed page 2 has certificate Be 10 this Certification:

P.0. Division of Vital Records, funeral Aftar or Attend after death Director: 2 To the Hospital within 24 hours To the Funerel B

St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (in yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 1□M 2XF Months Days Hours Min Yrs September 7,1915 Florida 83 262-01-6855 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limita Maryland St. Mary's Dameron Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20638 U.S.A. 49520 Lois Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Nevar Married 2 □ Married 1 Yes 2 No Specify: White h 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Metal Shop 12th Site Foreman 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Glisson Laura Dawson Wilkinson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 49520 Lois Lane, Dameron, MD 20638 Margo Parnell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/29/98Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility 21. Signatura of Funeral Service Licentee Mattingley-GardinerFuneral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 in the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, fone cause on each line. noo 23a. Pert1. Inter the disease, or complication shock, or earl failure. List only one car Approximata Intarval Between Onsat and Death Immediata Causa (Final disease or condition rasulting In death) Due to (or es a consequ RR Sequentially list conditions, it eny, leeding to immediate ceuse. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yee 2 No 3 Probably Winknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No

Mary

Parnell,

State Registrar

Medical

William Boyd II, 31. Date filed (Month, Day, Year)
DEC 2 9

5 Pending Investigation

6 Could not be

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 27. Manner of De th

1 Natural 2 Accident

3 ☐ Sulcide

29a. Certifian

4 Homicide

(Check only one)

29b. Signature end title of certifie

30. Name and address of pe

32. Registrar's Signature cherry

MD

who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day Year)

Leonardtown, MD 20650

2 ER/Outpatient 3 DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation in my obtained at the time.

1 Yes

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) and menner stated.

29c. License number

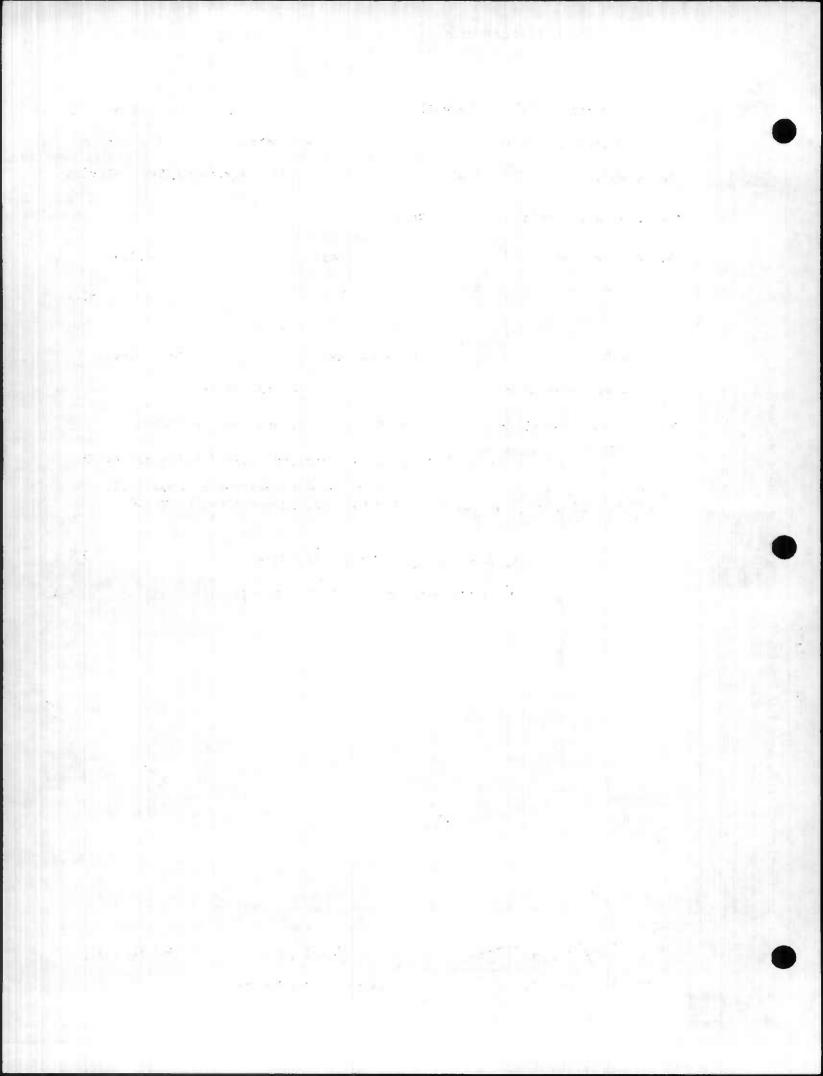
14281

2 No

28b. Time of

28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

**DHMH 16 Rev 6/95** 



214-05-5432

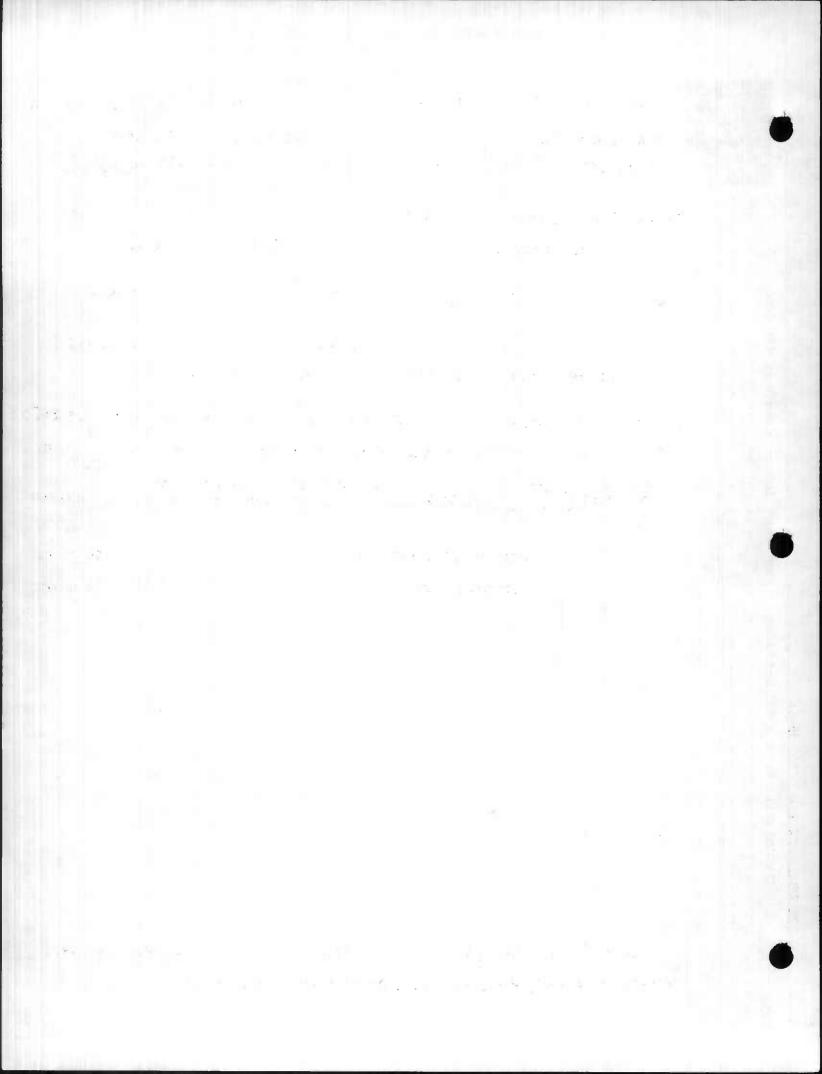
CLARENCE PAINTER

Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** William Painter, Clarence 28, 1998 December 10:45 AM /Medical 4a Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND 7. Aga (In yrs. last birthday). If Under 1 Yeer If Under 24 Hra. 5. Social Security Number 9. Birthplaca (Stata or Foraign Country) Mary Land 8. Data of Birth February 12 **Funeral** Days 214-05-5432 10XM 20 F Months Hours Min. Director Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If ferm 22 la marked other than "natural", or items 23a or 28a-f ahow my or other traumatic event, me handest Executed more matter notified at my or other traumatic event, me handest Executed. 10c, City, Town or Location 10e Stete 10b. County 10d. Inside City Limits 1 Yes 2 No MarylaND Alleghany Cumberland 10a. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21502 U.S.A. 115 Columbia Street Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No 1 ੴas, Giva Yaar or Dataa: W W Ⅱ 13. Was Decedant of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puerto Rican, etc.)
 1 ☐ Yas 2 ☐ No Specify: 14. Race - American Indian. 11. Marita! Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Specif White Baltimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) (Specify only highast grada complated) Collega (1-4or 5+) Eiamantary/Secondary (0-12) B&O Railroad Electrician 18, Mother's Name (First, Middle, Maidan Sumame) G. Nellie Rowe 17. Fathar's Name (First, Middla, Last)
William Be Ashby Painter 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Intormant's Name/Relationship (Type, Print) 720 Frederick St. Cumberland, Maryland 2/502 James E. Painter, I Son 20a. Method ot Disposition
1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place)
Sunset Memorial Park Data 20c. Location - City or Town, State 12-31-98 Cumberland, MD Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility Leasure-Stein Funeral Home 21. Signature of Funeral Service Licenses Avenue Cumberland MD21502 230 Baltimore Part 1. Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart tailure. List only one ceuse on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediate Causa (Fine) diseesa or condition resulting in death) a CHRONIC RENAL FAILURE 24 MONTHS Examiner Due to (or as a consequence of): Examiner 24 MONTHS NEPHROSCLEROSIS that the death certificate be executed physician and s the buriel-trans Sequantially list conditions, if any, taading to immediata cause. Entar Undarlying Cause (Disaasa or Injury that initiated evanta rasulting in death) Last Due to (or as a consaguanca of): Physician/Medicai Dua to (or es a consaquance of): 65 use for ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t b 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed paga 2 s has 1 Ves 2 No certificate Division of Vital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yes 25€No 1 Nonpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 55 Naturai 5 Panding death. 1 Yes 2 No Invastigation 2 Accidant after deat 6 Could not be datarmined 3 Suicida Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28t. Location (Streat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edicai completely (Check only one) To the To the To the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titia of certifiar 3 Loleus travo 1998 D14865 December 28 30. Nama and addrass of person who complated cause of deeth (Item 23a) (Type, Print) ROBUSTIANO BARRERA, M.D., MEMORIAL MEDICAL BUILDING CUMBERLAND MD 31. Date tiled (Month, Dey, Year) 32. Registrar's Signatura State DEC 3 0

**DHMH 16 Rev 6/95** 

Registrar



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8 4 1 9 0

				Certifica	te of	Death		Re	g. No.	4	117	U	
	1. Decedent'a Nema (First, Middle, Las	t)					2	. Dete of Death Month	1	Year	3. Tima o	f Death	
Physician /Medical	Glibert L. Plummer						D	ECENBER	18,19		1:25	P.M.	
Examiner	4e Facility Neme (If not institution, give	street and number)	1371			4b. City, Tov	wn, or Loca	tion of Death	4c. County of				
	Sacred Heart Hospital Cumberland  5 Social Security Number 6 Say 7 Ana (In yes, last hirthday) If Under 1 Year   If Under 24 Hrs.								Alle	gany	1		
Funeral Director	214-12-3137	ox 7. Age Q M 2□ F	(In yrs. last birth	Month:			Min.	Date of Birth (Month, Day, 26-Oct-19	_   .	9. Birthi Could	place (State ntry) land	or Foreign	
pue *	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside (											lity Limita	
with the Maryland a or 28a-f ahow be notified at Director	Maryland Allego	iny	Frostburg								1 Yes	2 🗆 No	
\$ p 2	10e. Street and Number 210 West	Mechanic S	treet	10f. 2	ip Code 215	32-		10	g. Citizen of W	hat Cou	ii Country?		
urs after ar, or he by Fur	11. Meritel Stetus  1 Nevar Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	If Yes, specif			oan, Mexican,	gin? (Speci , Puarto Ri	fy Yas or No- can, etc.)		, Whita,			
I 21215-0020 ed within 72 hours at vyglene. Per than "natural", or it, the thindel tend by I Completed by I	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			Decedent's Us Give kind of v life. DO NOT	ork done	during most	of working	1	6b. Kind of Bus				
Cl mara o	11	O	Pain	ter					Defense Contractor				
	17. Father's Nema (First, Middle, Last)					18. Mother	r's Name (	First, Middle, M	laiden Sumame	)			
Marylan 12 should be h and Mental 15 marked o traumatic ever	Robert Plummer					Haz	el Stre	ets					
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	19e. Informent's Name/Reletionship (7	ype, Print)	19b.	Mailing Addre	ss (Stree	V. E. 30719			City or Town, S	State, Zij	Code)		
P = N L	Blanche Plummer	Wife	Apt	324			Fros	tburg	Maryla	ind	21532	)_	
0 80 7 8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		20b. Place of I cemetery	Disposition (N , crematory or	other pla	aca)		Dete 2	Oc. Location - C	City or To	own, Stata		
Baltim Separtmen Mportant: Iny Injury	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licen;		Cumberian			ass of Facility		ec-98 C	umberla	na, N	naryian	3	
Baltin permit. F Departme importan eny injur page.	John K	Durg	1	THE PERSON				st Ave., Fr	ostburg, 1	MD 2	21532		
) Physician	23a, P. J. Enter the disease, or comp lock, or heert fallure. List only c	lications that caused ne cause on each lin	the death. Do no	ot enter the mo	ode of dy	ing, such as (	cardiac or i	raspiratory arra	st,		Approxima Intervel Be Onset and	tween	
/Medical Examiner	Immedieta Cause (Finel disease or condition resulting in death)	RESA	PIRAT	ORY		HAIL	UR	E. A	CUTE		2 WE	EKI	
uted ansitr	Immediate Cause (Finel disease or condition resulting in death)  a. HESPIRATOR HAILURE, ACUTE  Due to (or as a consequence of):  ACUTE. BILATERAL PNEUMONIA  Due to (or es a consequence of):  Cause (Disease or injury that initiated events  The initiated events  Due to (or es a consequence of):										4WZ	ZKI	
68760, fileate be amouted physician and as the burial-transit													
Me ass	rasulting in death) Last	- 1											
death cert death cert e attending ed for use										1			
P.O. hat the de dby the delached Physic	010	Contributing to death but not resulting in the underlying cause given in Pert I.  DSTRUCTIVE PULMONARY DISEASE							23b. Did tobacco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Unknown				
Records, P he law requires that s has been signed to ge 2 should be det ompleted by P								24a. Was an perform		81	fere autopsy vailable prior empletion of	to	
The lay page 2								1 ☐ Ye	5 2 K No		death?	No	
clan: clan: ector	25. Was case referred to medical examiner?	11	_	of Death (	Check only one	)							
- K 90 C	ILL TES AND	Hospital: 1 Inpatier			NA		4 Nursing Home 5 Residence 8 □Other (Specify)						
Attending P of death.  Setor: After the funeral iffication:	27. Manner of Death  1	28a. Date of Injun (Month, Day	Year) 28b. Ti	na of ury M	28c. Inju Wo	ny at ork? ]Yes 2 □ N		d. Describe ho	cribe how Injury occurred				
S SEE TO	3 Suicide 6 Could not be 4 Homicide determined	288. Piece of injury - At nome, ferm, street, fectory, office   201.							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital within 24 hours To the Funerel completely filled Medical C	29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the besis of and manner stat	examination and/	death occurre or investigetion	d et the t n, in my	ime, date and opinion, deet	d place, an h occurred	d due to the ca et the time, de	use(s) and man te end place, a	ner as s	stated. to the cause(	s)	
Toth Within	29b. Signature and title of certifier	un H.	mo	2	9c. Licen	se number 249	51	29	Dete signed	(Month,	Day, Year)	998	
ms	30. Name and address of person who co				land	21532						TPE	
State	31. Dete liled (Month, Day, Year)	32. Registra	r's Signature	1									

Gilbert L. Piummer Allegony Cumberland Sacred Heart Hospital 79 214-12-3137 Maryland 26-Oct-19 Frostburg Allegany Maryland 210 West Mechanic Street U.S.A. shidW. Defense Confractor Painter 11 Robert Plummer Hazel Streets Maryland 21532-Blanche Plummer Frostburg Apt. 324 19-Dec-98 Cumberland, Maryland Cumberland Crematory

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3 Time of Death 2. Dafa of Death Yea Month **Physician** Lloyd Weslev Payne December 21, 1998 8:05AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Forestville 4009 Suit Road Prince George's If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 5. Social Security Number **Funeral** Days 578-26-8864 MDM 20 F 73 Yrs Director June 18,1925 Maryland Usual Rasidence of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be nothed at 1 ☐ Yas 2 X No Directo Maryland Prince George's Forestville 10e. Streef and Number 10f. Zip Coda 10g. Citizen of Whaf Country? 20747 U.S.A. 4009 Suit Road Funeral filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Biack, Whita, atc 1 Nas 2 No 1943— If Yes, Giva Yaar or Datas: 1946 1 Nevar Married Married White 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coilega (1-4or 5+) Hygiene. 10th N/A Truck Driver Amoco Gas permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked oth any lolury or other treumatic event Page. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Etta Grieson James Lloyd Payne 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) Frances P. Payne (Wife) 4009 Suit Road Forestville, Maryland 20747 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dec. 24 Pata YMerial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1998 Cedar Hill Cemetery Suitland, Maryland 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md. 20735 art . Entar la disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** ARTERY DISEASE /Medical fmmediata Causa (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner law requires that the death certificate be axecuted attending physician and for use as the bunal-trans Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Lasf Box 68760. Dua fo (or as a consequanca of): 88 signed by the a d be detached f Part ff, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 | Yee 2 | No 3 | Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen s certificate has The 1 Ves 2 Dato 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner?
1. Yes 2□ No funeral director, Be 26. Place of Death (Check only one) Othar: 4 Nursing Homa 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Rasidanca 6 Othar (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Vannar of Death 1 XI atural Accidant Certification: 28c. Injury at Work? After t or Attending 5 Pending Invastigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: A completaly filled in by the f 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide Hospital Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifian (Check only one) 4 29c. Licansa number 29d. Data signed (Month, Day, Year) MD 30. Nagre and addrass of person who complated causa of death (Item 23a) (Type, Print) 9131 Piscataway Rd #280 Clinton, Md 20735 15

32. Regisfrar's Signatura

Gener

2

1998 ▶

Registrar

State

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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, I	ast)		00	rtificate of	Death	2. Data of Dee	Reg. No.	9 4	3. Time of Death		
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uneral rector		5. Sociel Security Number  243-12-4998  Usuel Residence of Decadent	Sex 1 M 2 F				If Undar 24 Hrs. Hours Min.	8. Date of Birth Month, Dey 9/17/17	Year)	COURT	eca (Stata or Fora EY, SC		
MOI III	-	10e. Stete 10b. County		10c. C	ity, Town or Lo	ocation				10	d. Insida City Lim		
28a-f show notified at	2	MD PG		TEM	PLE HI	LLS					XXYas 201		
or 28		10e. Street end Number				10f. Zip Coda			10g. Citizan of	What Count	ry?		
23a	3	3902 23RD PARKWA	Y			20748				JSA			
ral", or items 23s or 28s-f sho Examiner must be notified at 1 by Funeral Director	2	11. Marifal Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	12. Wes Dece Armed For 1 X Yes If Yes, Giye Yaar or De	2□No A	KMY	Was Decedent of H f Yas, specify Cub 1 ☐ Yes 2 X No	dispenic Origin? (Spen, Maxicen, Puerto Specify:	pecify Yas or No- Pican, etc.)	14. Rec Bla Specif	ce - Amarica ck, White, e y: BLA	tc.		
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merked imetic ev		HENRY PHILLIPS					MINNIE						
is me		19a. Informant's Name/Relationship		/tirpp\			end Number or Ru		r, City or Town,	Stata, Zip (	Code)		
m 27 her tr	-	ALLIE HOLMES PH	TPT152	(WIFE)		AS IUA, E	3,C,D,E,&						
important: if item 27 is any injury or other tra	6	20a. Method of Disposition  1 Burial 2 □ Cremation 3		State	cematary, crer	netory or othar pla			20c. Location	-10			
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any ir	21. Signeture of Funerei Sarvice Licensaa  22. Name end Addrass of Fecility JOHN T. RHINES CO., INC.  3030 12TH ST NE, DC 200												
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page 2								1 🗆 Y	es 2 XNo	10	Yes 2□ No		
rector, pag		25. Was casa referred to medicei exeminar?					26. Place of Deet	h (Check only or	re)				
5 C		1 XYes 2 No	Hospitel: 1 ☐ in	patienf 2 ER/Outpetient 3 DOA Oth			er: 4 Nursing Ho	ome 5 5 Raside	idence 8 Other (Specify)				
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completely filled in by the function Medical Certification	3 ☐ SuicIde 4 ☐ Homicide  8 ☐ Could not be determined  28e. Place of fnjury - At homa, ferm, sfreef, factory, office building, etc. (Specify)  28f. Location (Streat and Number or Rural Route City or Town, Stete)										Route Number,		
pletely fill	2	29a. Certifier (Check only one) Certifying P Medical Exa	hysician: To the b miner: On the bas end pranse	is of exemine	wledge, deeth tion and/or inv	occurred at the fin estigetion, in my o	ne, dete end place, pinion, daath occur	and due to the cored et the tima, d	euse(s) end ma ete and plece,	anner as ste end due fo t	ted. he ceuse(s)		
comple	2	9b. Signafura and title of certifiar	Ker	mes	h	29c. Licenso 95 8	e number	2	9d. Data signe 12/21/9		ey, Year)		
	3	0. Neme and address of person who					AVENUE S	E, DC 20	0032. #	213			
	1	BARRY SMITH, MD 1328 SOUTHERN AVENUE SE, DC 20032, #213 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture											

DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 4a. Facility Nama (If not institution, give street and number) KOBINSON DECEMBER /Medical 4b. City, Town, or Location of Deeth **Examiner** QUANTICO RD If Under 1 Year If Under 24 Hrs. 8. Dete 100m 100 7. Aga (in yrs. lest birthday) 9. Birthplece (State or Foreign Sex 1 M 2□ F **Funeral** Days Houra Yrs. Director Usual Residence of Decedant the Meryland 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylar Department of Heelith and Mental Hygiene. Important: If them 27 is merked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Modical Examiner meather tooling at QUANTICO 1 Yes 2 KNo Wicomico Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6145 QUANTICO US 21856 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yaer or Detes: 11. Marital Status 13. Wea Dacedant of Hispanic Origin? (Specify Yaa or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2 No P Specify: RLACK 3 Widowed 4 Divorced Completed 18e. Decedant's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE ILYEARS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Surneme) ROBINSON PRICE LEVIN W. HUOLA 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) ROBINSON QUANTICO MD 3/856 Dete 20c. Location - City or Town, Stata EDINA WIFE 6145 COVANTICO RD 20b. Piece of Disposition (Nema of cematery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 19/28/98 QUANTICO, NOD 4 □ Donation 5 □ Other (Specify) HD OF CK CEMETERY 21. Signature of Funerei Sarvice Licensee 22. Name and Address of Ficility MESSIX Funeral Home Ro SIVALE Md. A1814 23a. Part1. Storer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haart failure. List only ona cause on sech lina. PO BOX 61 Physician /Medical tmmediate Ceuse (Finel disaesa or condition resulting in deeth) 6 months Metestatic Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the build-transit completely filled in by the funeral director, page 2 should be detached for use as the build-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initieted events rasulting in death) Laat Due to (or es a consequence of): attending physician for use as the buria Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of causa of death? TLIYES 2LINO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Medical Certification: To 1 ☐ Yes 5 sidence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how tnjury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accidant 6 Could not be 3 ☐ Sulcida 28e. Plece of injury - At homa, ferm, street, fectory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida medical Examinar: On the best of my knowledge, deeth occurred at tha time, dete end plece, end due to the ceuse(s) and manner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and mennar stated. 29a, Certifier

State

29b. Signatura and itle of certifian

31. Dete filed (Month, Dey, Year)
DEC 2 8 1998

Registrar

**DHMH 16 Rev 6/95** 

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760.

Division of Vital

32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Covall, UND

29c. Licansa number

026278

12-26-78

29d. Data signed (Month, Day, Year)

Solich, MD 21801

ned, while the set of 

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year A. R166S 10/5pm EDWARDINA Dec. 1998 20 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death County GENERAL HOSDITAL HOWARD. 10 WATED Columbia MD 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Date of Birth (Month, Day, Year) 1 M 2 N Months Days Hours Min. 217-84-2345 35 July 18, 1963 Maryland Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d, Insida City Limits MD Howard Ellicott City 1 ☐ Yas 2 No 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 4911 Webbed Foot Way 21043 U.S.A. 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1X Never Married 2 Married If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedant'a Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant'a Education (Specify only highest grade complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Title Clerk Automotive 17. Fathar'a Nama (First, Middla, Last) 16. Mothar's Nama (First, Middle, Maiden Sumama) Joseph Lucther Charlotte E. Williams 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Raletionship (Type, Print) Charlotte Williams Riggs (mother) 4911 Webbed Foot Way, Ellicott City, MD 21043 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, State 1 Burlal 2 Cramation 3 Ramoval from Stata Carroll Cremation Serv. 12/24/98 Hampstead, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 21. Signature of Funaral Sarvice Licansee Brian Naugata Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complication, that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death (STAPHILOTORUS) . Meticillin Risutant Immediata Causa (Final Staph. Aureus disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that Initiated events rasulting In daath) Last Dua to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 1abetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Tultiple Sclerosis 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida 28a. Pleca of Injury · At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide

Examiner physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 50 attending p ed by the a signed by t peen : page 2 s this certificate or Attending Physician: director, After this ofter death. Director: A To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Wedical Examinar maint be notified at

Pages 1 and 2 should be filed within 72 hours after neal of Health and Mental Hygiene.
mt: if item 27 is marked other than "natural", or item yor other tearmale event, the Medical Esternance in yor other tearmale.

Department of important: If any injury or page.

**Physician** /Medical

Examine

Physician/Medical

2

Completed

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Certification:

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Baltimore,

with the Manyland

death 1

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certifies alber MD 29c. License number D42465 29d. Date signed (Month, Day, Year) Dec. 21, 1998.

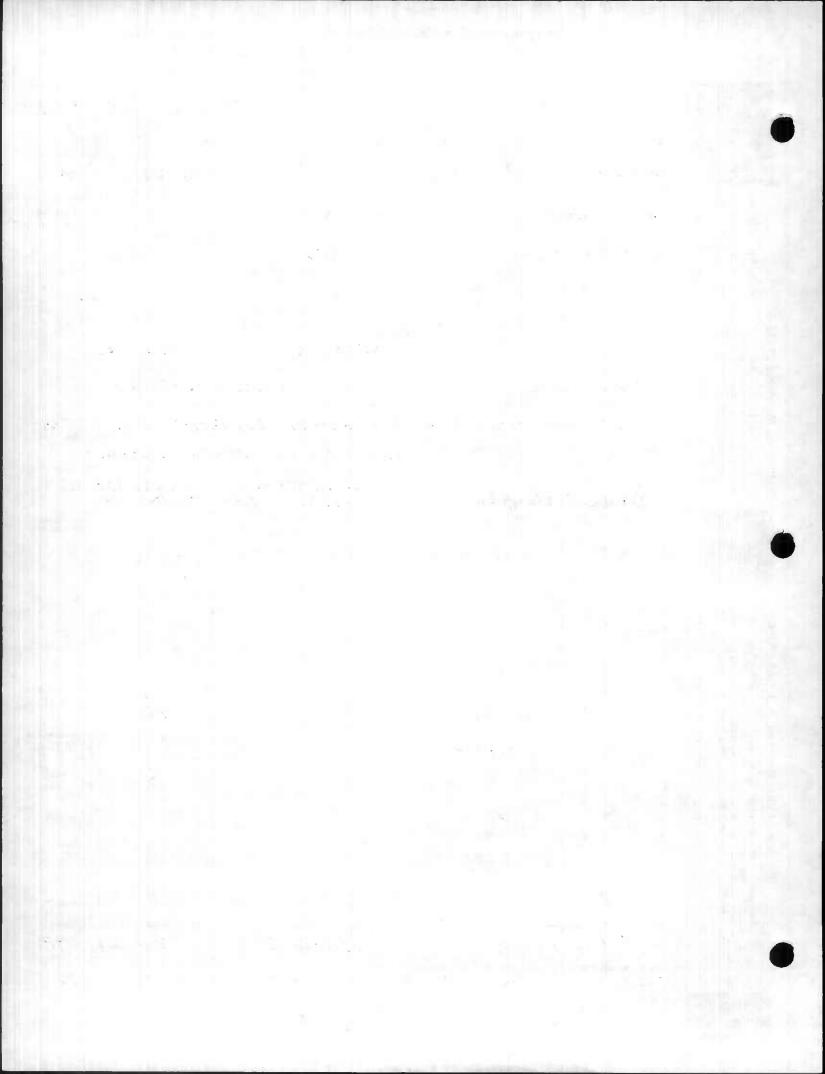
30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print) 2 Knoll NORTH DU. Columbia

21045 - N. SAUVEY M.D.

State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signatura



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** Anita Elizabeth Raley December 1998 9:37 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (State or Foraign Country) **Funeral** 1 M 2 F Yrs. 220-16-8739 72 February 21,1926 Maryland Director Usuat Rasidance of Decedant 10a. State 10c. City, Town or Location 10d. insida City Limita r than "natural", or items 23s or 28s-f show the Medical Examiner next be notified at 1 ☐ Yas 2 BNo Maryland St. Mary's Dameron 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 18300 St. Jeromes Neck Road 20628 United States Funeral Was Decedent of Hispanic Origin? (Specify Yaa or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar In U,S. 11. Marital Status Armed Forcas ☐ Yas 2 No Yas, Giva 1 Naver Married 2 Married 1 ☐ Yas 2 ■ No Specify: by n Yas, Giva Year or Datas: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) United States Clerk Postal Service 7 is marked other traumatic avant, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 end 2 should be filk Department of Heelth and Mental Hy Important: if item 27 is marked oth any Injury or other traumatic avam page. Francis Chester Cullison Anna Marie Peacock 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) Robert W. Raley, Husband 18300 St. Jeromes Neck ROad, Dameron, MD 20628 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from Stata St. Michael's Cemetery 12-29-98 Ridge, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Juneral Service Livesee 22. Name and Address of Facility Well. Svard N. Brinsffeld, Jr. Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Edward 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical **Examiner** Dua to (or as Examiner ettending physicien end for use es the buriaf-transit Due Saquentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants (or as a consaquanca of Physician/Medical Due to (or as a consequence of): rasulting in death) Last Part II. Other aignificant conditions contributing to death bytynot rasulting in the underlying cause given in Part 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yea 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 2 Director: After this d in by the funeral d 28d. Dascribe how Injury occurred 27. Mannar of Death 28b. Tima of 28c. injury at Work? Certification: 1 Natural 2 Accident 5 Panding investigation 1 Tas 2 No 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida within 24 hours of To the Funeral Di completely filled in Celtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the vasis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause of manner states. 29a. Cartifian edical (Check only one) hination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s)

The lew requires that the death certificate be executed ELIZABETH Records. Division of Vital Physician: the Hospital or Attending

P.O. Box 68760,

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other than

Registrar

DHMH 16 Rev 6/95

JARBOE M.D PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636 JAMES P. 31. Data filad (Month, Day, Yaar)
DEC 2 State 1998

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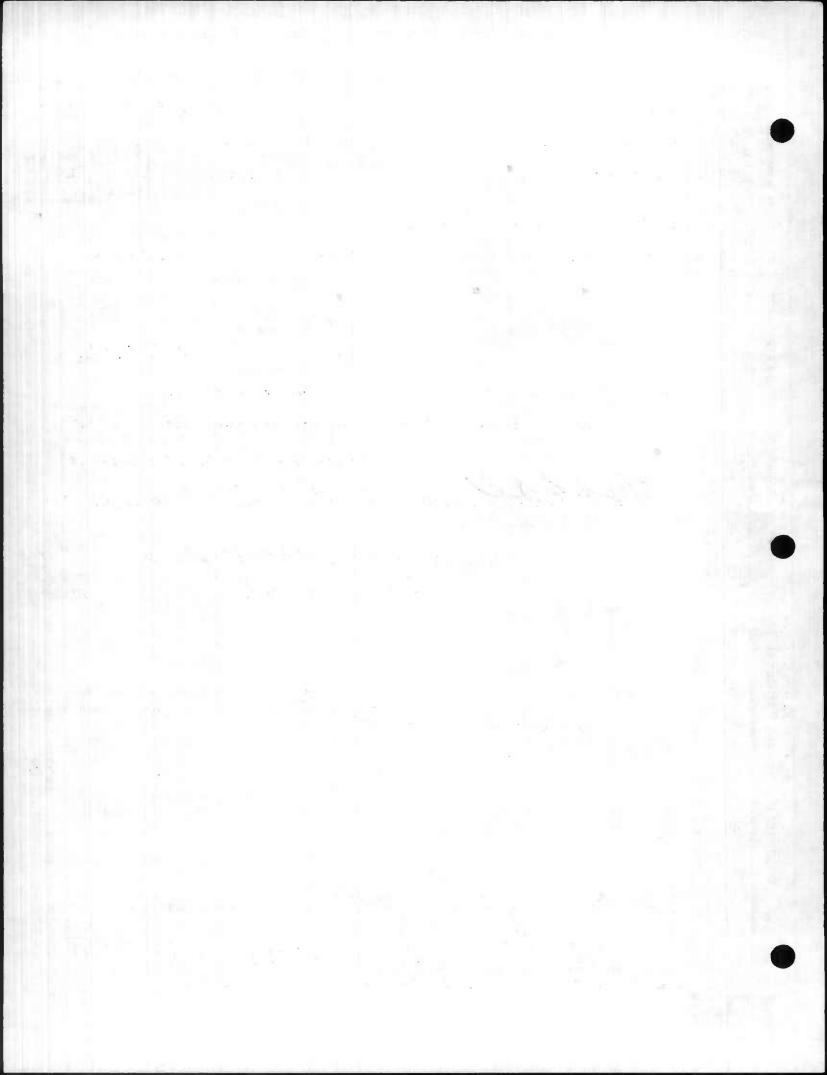
30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

29b. Signatura and title of

32. Registrar's Signatura

29c. License number

29d. Date signed (Month, Day, Year)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 3. Time of Death 2. Deta of Death Day Month Francis Edwin Rinker 25, Dec. 1998 :45 P.M. 4s Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 □ F Months 214-07-4489 87 Yrs. 6,1911 Maryland July Usuei Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 220 Somerville Ave. A-213 21502 USA 12. Wes Decedant Evar in U.S. Armed Forcas? ½√yes 2 □ No 7/26/44-IYas, Giva Yaer or Datas: 12/1/45 Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian. Bieck, White, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b, Kind of Businass/Industry Elementary/Secondary (0-12) 1 2 Collega (1-4or 5+) Construction Worker Construction 18. Mothar's Nama (First, Middle, Maidan Sumame) 17. Fathar's Nama (First, Middle, Last) James R. Rinker Effie O'Neal 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 21502 19a. Informant's Name/Raiationship (Type, Print) Genevieve Rinker/Wife 220 Somerville Ave A-213 Cumberland, Md. 20b. Plece of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Pata 12/30/98 1 ☐ Murial 2 □ Cramation 3 □ Removel from Stata 4 □ Donation 5 □ Other (Specify) Rocky Gap Vet. Cemetery Cumberland, Md/ 21. Signatura of Funaral Service Licensee 22. Nama end Address of Fecility Leasure-Stein Funeral Home 230 Baltimore Cumberland, Md. 21502 23a. Pert1. Enter the disease, or complication if at caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or heart failure. List only one cause on each line. **Approximste** Intarvai Batween Onsat end Deeth Immediata Cause (Final disaasa or condition rasulting In daath) year 065 Dua to (or as a consequence of): Sequantially ilst conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated avents resulting in daath) Last Dua to (or as a consaguance of): Due to (or es e consequence of): 23b. Did tobscco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Homa 5 Rasidance 6 Othar (Specify)

**Physician** /Medical Examiner that the death certificate be executed

permit. Page Department of Important: If any Injury or once.

**Physician** 

/Medical

Examiner

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Funeral

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Completed

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of Health and Mental Hyglene.
Int: If item 27 Is marked other than "natural", or itema 23s or 28s-f show any or other traumatic event, in shedical Exertines man be notified at any or other traumatic event, in shedical Exertines man be notified at

Baltimore, Maryland 21215-0020

Examiner physician and s the bunal-transit Physician/Medicai þ Completed page 2 s Be

attending pl signed by the a d be detached f has certificata Certification: To this funeral aftar death. filled in by

Division of Vital Records, P.O. Box 68760

or Attending Physician:

Hospital

24 hours a Medical pletaly To the I within 2 State Registrar

SUNIL GUP TA

27. Mennar of Death

1. Naturel

2 Accidant

4 Homicida

(Check only one)

3 Suicida

29a. Certifier

5 Panding

investigation

6 ☐ Could not be detarmined

29b. Signature and title of dertifie bund MD

28a. Piace of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

28b. Tima of

28c. Injury at Work?

🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29c. License number 29d. Date signed (Month, Day, Year) Dec 28, 1998 1) 33280

30. Nema and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

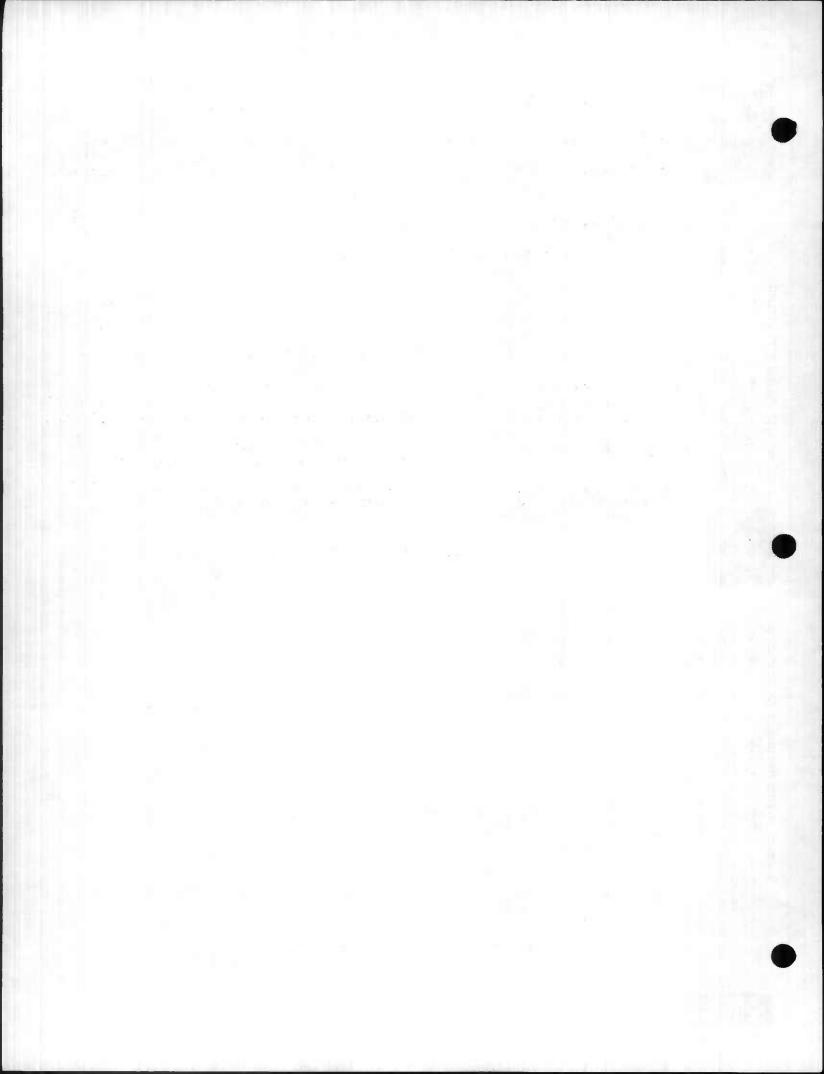
28a. Deta of Injury (Month, Day Year)

625 KEN7 AVE 32. Registrar's Signatura

28d. Dascribe how injury occurred

CUMBERLAND MD 21502

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Month DECEMBER 26 1998 01:10 AM DOROTHY LEE RITCHIE 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys 1 □ M 2 🗓 F 70 213-24-7142 Yrs MARYLAND MAY 6 1928 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14908 UHL HIGHWAY S.E. 21502 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE 30XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondery (0-12) College (1-4or 5+) TOWN & COUNTRY/SHEETZ/M.V.A. CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Surname) OTIS EVERETT GEORGIA ZIMMERLY 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA L. GLAZE DAUGHTER 14908 UHL HIGHWAY S.E. CUMBERLAND MARYLAND 21502 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from State DAVIS MEMORIAL CEMETERY DEC 29 1998 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility MERRITT-ADAMS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errast, intervel Between the control of the control Onset and Death Immediate Cause (Final disease or condition resulting in death) e Coronary Artery Disease 20 years Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaese or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopay findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Mangar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Natural Accident 5 Panding investigation 1 Tyes 2 No 28e. Place of Injury - At home, ferm, atreet, factory, office building, atc. (Specify)

The law requires that the death certificete be executed buriel-tran P.O. Box 68760. physician the USB 85 0 ed by the al been signed is should be det Division of Vital Records. page 2 certificate Hospital or Attending Physician: funeral director, this After s after death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Wed cal

or other trac

Department of important: If any Injury or

**Physician** 

/Medical

Examine

Pages 1 and 2 should be nent of Health and Mental

Director

Funeral

Completed by

Be

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the Marylend

death

filed within 72 hours after

21215-0020

Baltimore, Maryland

Physician/Medical by Completed Be Certification: To

29a, Certifier

6 Could not be datarmined 3 Suicide 4 T Homicide

29h. Spnature and title of certifles

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician To the best of my knowledga, death occurred et the tima, data and placa, and due to the ceuse(s) end mannar as stated.

| Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the tima, date and placa, and due to the cause(s) and mennar stated.

29d. Date signed (Month, Day,

led cause of deeth (Item 23e) (Type, Print) 30. Name end eddress of person who comple

MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND DR GUY FISCUS 21502

29c. License number

State Registrar

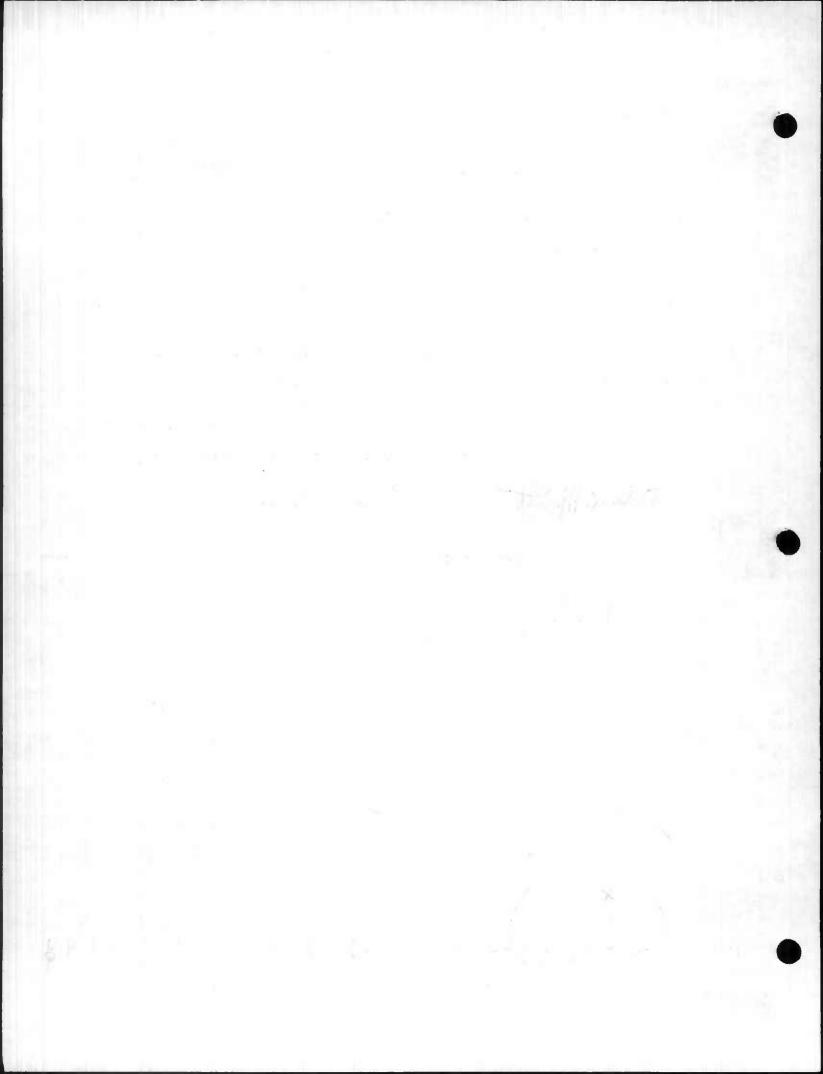
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Medical completely

To the Hospital within 24 hours a To the Funeral E





## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day December 17,1998 0230 a.m. James Paul Rogers I 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Sacred Heart Hospital Allegany Cumberland If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) NC 8. Dete of Birth (Month, Day, Year) Days 100 M 20 F Months Mar 10, 86 254-03-3711 Usual Residence of Deceder 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 1X Yes 2 No LaVale Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Roger Way 21502 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritat Status Bleck, White, etc. 1 ☐ Never Merried 2 X Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting 12 Certified Public Accountant 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) James David Rogers Lola (Bradley) 19a. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Rogers-wife 5 Roger Way LaVale MD 21502 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SS Peter Paul Cemetery Cumberland MD 12/19 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licenses Cumberland MD 21502 tions that cau led the death. Do not enter the mode of dying, such as cardiac or respiretory errest, cause on each line. 23a. Part1. Enter the disease, or complications, or heart tailure. List on the complication of the complication of the complex Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): 23b. Dtd tobacco use contribute to the cause of death? 1 Yan 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

**Physician** /Medical Examiner

Box 68760.

P.O.

Records,

Division of Vital

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 ahould be filled within 72 hours after death 1 Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural" ~ in page 1 in the page 27 is marked other than "natural" ~ in page 2.

Director

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Completed

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physician and the burial-transit The law requires that the death certificate be assecuted certificate or Attending Physician: this After

Examiner Physician/Medical Completed by 8 Medical Certification: To

4 Homicide

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun State Registrar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tes 2 No 1 Yas 2 No

25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Netural 5 Pending 1 Yes 2 No 2 Accident investigation 8 Could not be 3 Suicide

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. (Check only one) iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

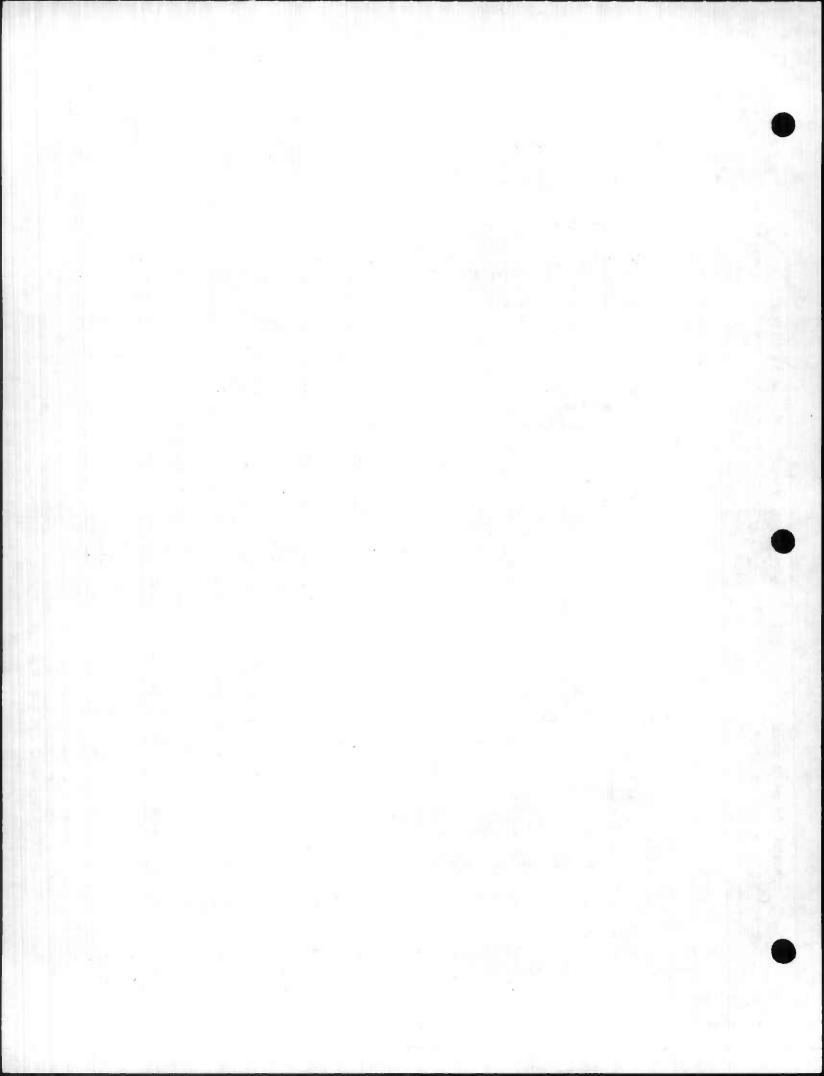
1. Wylm

December / /, 1998

eted cause of death (Item 23a) (Type, Print)

larn 32. Registrar'a Signature rostburg

DHMH 16 Rav 6/95



#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle 1 ast) 2. Data of Death 3. Tima of Death SUSIE W. RAGINS December 12, 1998 7:25pm 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HILLHAVEN NURSING HOME ADELPHI PRINCE GEORGES If Under 1 Yaar If Under 24 Hrs. Months Deys Hours Min. 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 1□M 20 F Yrs 579-09-1733 83 Sept. 17, 1915 South Carolina Usuai Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1- Yas 2 No Washington, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5108 KANSAS AVE. N.W. 20011 U.S.A. 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 1 ☐ Never Merrled 2 ☐ Married 1 ☐ Yas 2♥ No If Yes, Giva Yaar or Datas: 1☐ Yas 2√ No 3 Widowed 4 □ Divorced Specify: BLACK 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12th CLERK FEDERAL GOVERNMENT 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) EDWARD WATSON MILLIE FLUDD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) BETTY HARDERMAN/DAUGHTER 4341 GREENBERRY LANE, ANNANDALE VA. 22003 20a. Method of Disposition 20b. Piaca of Disposition (Nama of cametery, cramatory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FORT LINCOLN CEMETERY 12/19/98 BRENTWOOD, MD. 22. Nema and Addrass of Facility JOHNSON & JENKINS INC. 21. Signature y Funerel Parvice Lightsee 716 KENNEDY ST., N.W. WASH. D.C. 20011 Pag. Entar the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death Immediata Causa (Finai brownelen rendent disaasa or condition rasulting in daath) Dua to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Reabeles 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Wara autopsy findings aveilabla prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 26. Placa of Death (Check only ona) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred

Physician /Medical Examiner

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To the Hospital o within 24 hours af To the Funerel Di completely filled la

**Physician** 

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f sho trsumstic svent, the Medical Examinal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter d
Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Example.

Baltimore, Maryland 21215-0020

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25. Was casa rafarred to madical

27. Mannar of Death 5 Panding Investigation 1 Naturel 2 Accident 3 Suicide

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28a. Placa of injury - At homa, farm, street, fectory, offica building, atc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and piece, and dua to tha causa(s) and mannar as stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stetad. 29b. Signetura and titla of certifie

29c. Licansa number 0367/6 29d. Data signed (Month, Day, Year) Decembe 16, 1998

30. Nama and addrass of person for complated causa of death (itam 23a) (Type, Print) 831) Cherry line Loure/ Md.2020 -undrut

31. Data filed (Month, Day, Year) DEC 2 1 1998

4 ☐ Homicida

29a. Certifian

2. Ragistrar's Signatura

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** December 17, 1998 04 Russell Bladen /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOX CHASE Montgomery 7. Age (In yrs. last birthday)

Whom Deys Hours Min.

Oct. 1916

North Deys Hours Min.

Oct. 1916 Silver Spring, MD 2015 East West Highway 5. Social Security Number 9. Birthplaca (State or Foreign Country)
Warrenton, VA **Funeral** 224-16-6325 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Exampler must be notified at Washington, DC 1√ Yas 2 No Director 10f. Zip Code 20011 10e. Street and Number 10g. Citizen of What Country United States permit. Pages 1 and 2 should be filled within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frams 23e or 2 and 1 physical Examiner must be 25 bots. 5012 4th Street NW Funeral 14. Raca - American Indian, Black, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1∑ Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Merried Specify Black 21215-0020 1 ☐ Yes 2 X No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public Schools Engineer 12 Baitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Jennie Clay Russell Bladen Russell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5012 4th Street NW, Washington, DC 20011 Dolores C. Russell / Wife 20b. Place of Disposition (Name of 20a. Mathod of Disposition Data 20c. Location - City or Town, State Quantico National Cemetery12/23/98 Triangle, VA 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Pope Funeral Home 5538 Marlboro Pike / Forestville, MD 20747 M1085 23a. Part1. Enter the disease or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) /Medical Carcinoma Months Examine Due to (or as a consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical Due to (or as a consequence of): P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown / arline Diabetes millitis Records, þ 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 ☐ Yes 20 No Division of Vital or Attending Physician: 25. Was casa referred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 10 1 Yas 2 No this funaral 27. Manner of Death 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 MNatural after death. 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in 24 hours a Funeral D Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

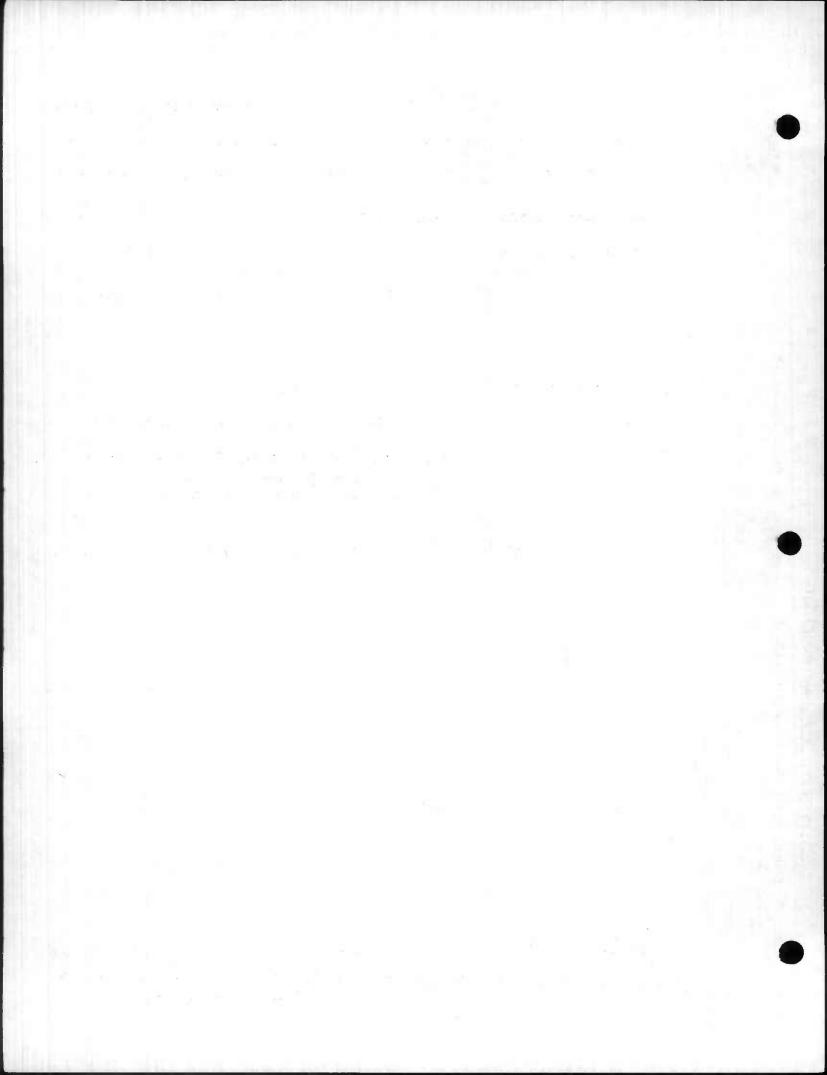
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completely fi (Check only one) ş 29b. Signeture and title of certified 29c. Licensa number 29d. Date signed (Month, Day, Year) 0 D0052255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #404B Silver Sfring, M.D. 20910 8609 2nd Ejaz Muhammad Ave 31. Data tiled (Month, Day, Year)
DEC 2 1 1998 3. Registrar's Signature State Registrar

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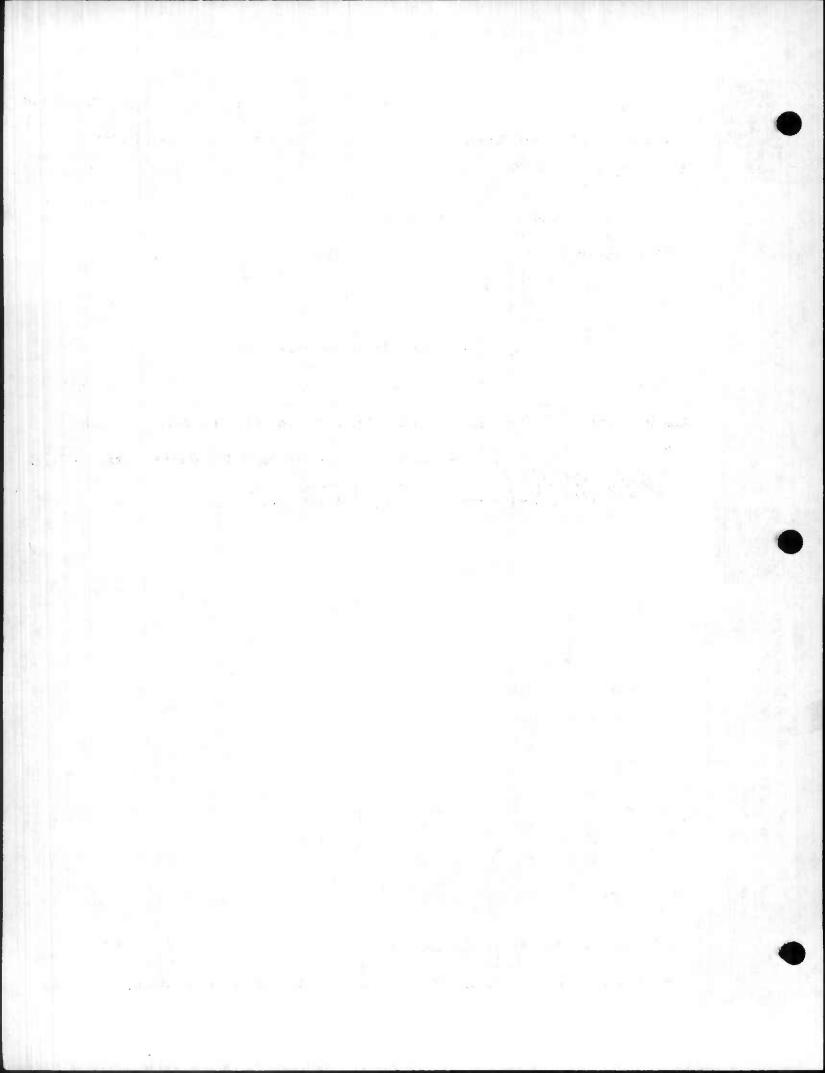
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Smith, Lec Harold Ir.



State of Maryland / Department of Health and Mental Hygiene 98 4 1202

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a. Facility Nama (If not institution, g Twin Oaks Retir Social Security Number 212-24-3753  Sual Residence of Decedent Da. State 10b. County MD Washing De. Street and Number 16137 Clovertor 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad (Specify only highast g Elementery/Secondery (0-12) 12 7. Fether's Nema (First, Middle, Last Cecil 9a. Informant's Name/Relationship Lee D. Shank Da. Method of Disposition 1 Burial 2 Cremation 3	Tement Centers  Sex 1 M 2 F 7. Aga  1 M 2 F 7.	72 10c. City, Tow Willi ever in U,S.	Yrs.  Vn or Loc  amsp	If Undar Months  cation  Oor†  10f. Zlp  Wes Decer i Yes, sper	Days  Code 2179  dent of Heify Cub	Willia If Undar 24 Hours	amspo Hrs. & Min.	Dec. ation of Deeth Dr† 3. Date of Birth (Month, Dey Feb. 2	26, 19 4c. County WASH 2, 1926  Og. Citizan of V USA	998 of Deeth HINGT( 9. Birthp Coun Wes	ON laca (State or Fo fry) Virgin Od. Inside City Li 1 Yes 2 try? an Indian,	
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Da. State  MD  Washing  De. Street end Number  16137 Clovertor  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorcad  15. Decadent's I (Specify only highast g  Elementery/Secondery (0-12)  12  7. Fether's Nema (First, Middle, Last  Cecil  9a. Informant's Name/Relationship  Lee D. Shank  Da. Method of Disposition  1 Burial 2 Cremation 3	12. Wes Decedent E Armed Forces? 1 Tes 2 M N If Yes, Give Year or Detes: Education rade completed)  College (1-4or 5-	Willi ever in U,S. o	13. W	10f. Zip	2179 dent of F cify Cub	fispenic Originan, Mexican, I	n? (Speci Puerto Ri		USA 14. Rec	What Coun	1 ☐ Yes 2 ☑ try? an Indian,	
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16137 Clovertor  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorcad  15. Decadent's I (Specify only highast g  Elementery/Secondery (0-12)  12  7. Fether's Nema (First, Middle, Last Cecil  9a. Informant's Name/Relationship  Lee D. Shank  Da. Method of Disposition  1 Burial 2 Cremation 3	12. Wes Decedent E Armed Forces?  1	0 16a	1	Ves Deced Yes, spec	2179 dent of F cify Cub	fispenic Originan, Mexican, I	n? (Speci Puerto Ri		USA 14. Rec	e - Americ	an Indian,	
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7. Fether's Nema (First, Middle, Las Cecil) 9a. Informant's Name/Relationship Lee D. Shank 1a. Method of Disposition 1 Burial 2 Cremation 3			dmin						Utilit	ty		
9a. Informant's Name/Relationship  Lee D. Shank  Da. Method of Disposition  1 Burial 2 Cremation 3						18. Mother's	Neme (	eme (First, Middle, Meiden Surname)				
Lee D. Shank Da. Method of Disposition 1 Burial 2 Cremation 3			Sha	w		Anni				-	endall	
Lee D. Shank Da. Method of Disposition 1 Burial 2 Cremation 3	(Type, Print)	19t			(Street			Kuykendall  Rural Route Number, City or Town, Stata, Zip Code)				
Da. Method of Disposition	(husbar								port, M			
20a. Method of Disposition    Burlai 2   Cremation 3   Removal from State     4   Donation 5   Other (Specify)   Green   awn Memorial   Park Dec. 29, 1998   Williamsport, MD 21  21. Signetu   Enter the diseasa, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiretory errest,   Approximate Intervel Between   Approximate Intervel Between   Date   20c. Location - City or Town, Stete     20c. Location												
3a. Pert1. Enter the disease, or con shock, or peer feilure. List only nmediete Ceuse (Finel seese or condition sulting in deeth)	e. Ova	the deeth. Do	an	cer		ng, such as ca	rdiac or i	respiretory erro	est,	- 1	Approximete Intervel Between Onset and Deeth	
equentially list conditions, eny, leading to immediate ause. Enter Underlying ause (Diseese or Injury et initieted avents suiting in death) Last	c											
ut if Other elgolfloont conditions	contribution to don't but	and annualism to	a the same	de de la cons	I	and Book						
		not resulting li	n the un	derlying c	ause giv	ren in Pert I.			· V		the cause of de ably 4 - Unkr	
hy pothyroid	ism							completion o			liable prior to npietion of causa	
								1□Ye	s 2 No		Yes 2 No	
. Was case referred to medical exeminer?	Hospital:				Out		Deeth (	Check only on	ө)		Acc chi d	
	1 L Inpatien				^	4   Nursi					Assisted	
1 Neturei 5 Pending	(Month, Day			M 2			280	28d. Describe how injury occurred				
3 Sulcide 6 Could not be determined	286. Pieca of injur	y - At home, fa (Specify)	ırm, stre	et, fectory	, offica		281	Location (St. City or Town	reet and Numb n, State)	er or Rurai	Routa Number,	
27. Mennar of Deeth   Neturei   2   Accidant   3   Sulcide   4   Homlcide   29e. Certifier (Check only one)   29e. Certifier (Check only one)   29e. Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth ocentral properties.								d due to the ce at the time, de	euse(s) end me eta and piaca, a	nner es ste and due to	ited. tha cause(s)	
29b. Signature end titla of certifiar 29c. Licanse number								25	9d. Dete signed	Month, D	ay, Year)	
Deprthia Kuttner-Sands no D47451						1	12/28/98					
	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)  Dr. Cynthia Kuttner—Sands ,MD 11110 Medical Campus Rd. Hagerstown, MI											
erick in the second sec	Was case referred to medical exeminer?  Id Yes 2 No  Wenger of Deeth Neturel investigation of Homicide  Certifier (Check only one)  Signature end titla of certifier  Curtifier (Check only one)  Signature end titla of certifier  Was asserted to medical exemined investigation of the determined of the could not the determined one)	Was case referred to medical exeminer?  If yes 2 No  Wear of Deeth Notice 1 Pending investigation and Suicide 4 Homicide  Certifier (Check only one)  Signature end titla of certifiar  Curthea Kuthea  Value of death but decimined  A.  If Other significant conditions contributing to death but death but and the performance of the pending to death but and the pending the pendi	Was case referred to medical exeminer?  Wenger of Deeth Neturel 5   Pending investigation 3   Sulcide 4   Homicide    Certifier (Check only one)   Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check only one)    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Certifier (Check one)    Signature end tittle of certifier    Signature end tittle of certifier    Signature end tittle of certifier    Signature end tittle end tittle end tittle end titt	Was case referred to medical exeminer?    Was case referred to medical exeminer?   Hospitel: 1   Inpatient 2   ER/Outpetient	If the death of the significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contribution and in the	inting in death) Last  d	If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical in I inpatient 2 ER/Outpetient 3 DOA of ther: 4 Nursi investigation investigation investigation investigation investigation and/or investigation, in my opinion, deeth of the determined of title of certifier in title of certifier conditions.  Signature end title of certifier 29c. Licanse number	If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  Was case referred to medical exeminer?  In yes 2 No  Other: 4 Nursing Home Work?  Work?  Month, Day Year) Exeminer of Injury exeminer exemption investigation investigation exemption.  Succident 1 Yes 2 No  Certifier (Check only one)  Madical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred end menner steted.  Signature end title of certifier 29c. Licanse number	If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did to 1   Ye   Ye   Yes   2   Yes	If, Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use consequence of).  1 Yes 2 No  24e. Was an eutopsy performed?  1 Yes 2 No  Was case referred to medical exeminer?  1 Yes 2 No  Wenger of Death (Check only one)  Wenger of Death (Check only one)  28e. Dete of Injury at Nort?  1 Yes 2 No  Work?  1 Yes 2 No  28e. Dete of Injury At home, farm, street, fectory, offica  28f. Location (Street and Numb Cityer Town, State)  1 Certifier (Check only one)  29d. Dete signed  29d. Dete signed  29d. Dete signed  29d. Dete signed  29d. Dete signed  29d. Dete signed	If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to 1   Yes 2   No 3   Prob.	



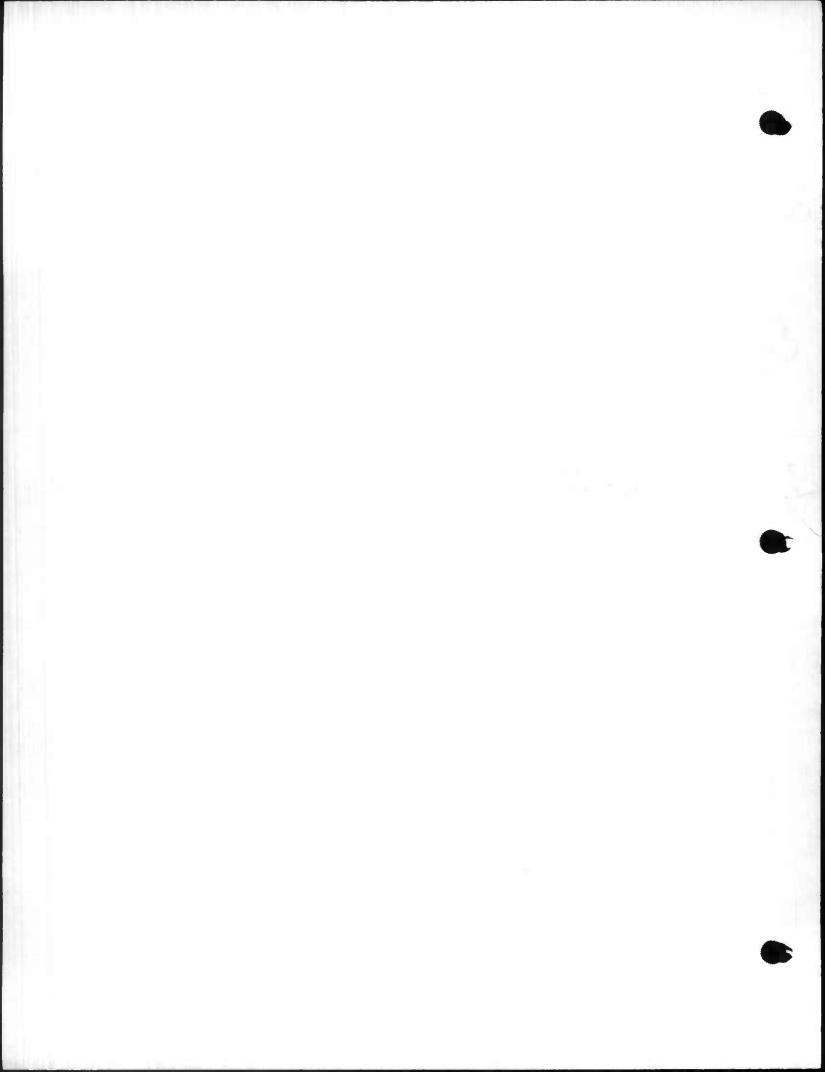
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYL	LAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIEN
	CERTIFICATE	OF DEATH	REG. NO.

	1 - FOR STATE OF N	IARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
	Jean M Stat	707		December 24	1998 1345 M
	4. SOCIAL SECURITY NUMBER 5. SEX		UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)
	354-16-3814 10M2 XF	75 YAS.		August 13, 192	
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number)  PESIDENCE OF DECEDENT  RESIDENCE OF DECEDENT	nel	Baltimore	DEATH 9c.	Baltimore
SE C	10e. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION		10d, INSIDE CITY
1	Maryland Washington	Ha	agerstown		LIMITS?
FUNERAL	13211 Woodbine Lane		101. ZIP CODE 2 1	742 log.	U.S.A.
2		EVER IN U.S. ARMED		ANIC ORIGIN? (Specify Yes or No	0— 14. RACE — American Indian,
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced  FORCES? 1  IF YES, GIVE W	☐ YES 2 NO AR OR DATES	If yes, specify Cuban, Mex 1 YES 2 X NO Spe		Black, White, etc. Specify: White
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USI	JAL OCCUPATION	16b. KIND OF BUSINESS	S/INDUSTRY
<u> </u>	Elementary/Secondary (0-12) College (1-4 or 5 +	Me. Do NOT use re	· ·		
COMPLETED	0-12 4	house v	vife	Own home	
	17. FATHER'S NAME (First, Middle, Last)	.111		NAME (First, Middle, Meiden Sumer	
띪		lloch		Majorie Verbe	
2	Mr. Philip J. Statton/son			al Route Number, City or Town, State agerstown, Mar	
	20e, METHOD OF DISPOSITION	20b.PLACEAND DATE OF D			ryland 21742 N — City or Town, State
	1 ☑ Burlei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	cometery, cremajory or other Rose Hill	place)	DATE 20c. LOCATION	N — City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Ause HIII		Z8,1998 Hage:	rstown, Maryland
	Satth Minin		415 East Wils	on Blvd., Hage	erstown, Maryland
	23. PART I. Enter the diseases, or complications that	caused the death. Do not	enter the mode of dying, e	ich ee cerdiec or reepiratory	y erreal, Approximate
	IMMEDIATE CAUSE (Final	se on esch line.			Interval Between Onset and Death
	resulting in death) a. DUE TO (	eumo thoray or as a consequence of):			
Z	S	POSIS DR AS A CONSEQUENCE OF):			
CERTIFICATION			K		
3	CAUSE (Disease or Injury	Decedial in f	arction		
Ē	moulting in death) I 40T				
B		spharema			
¥	PART II. Other significant conditions contributing to	death but not resulting in ti	na undariying ceuse given i	n Part I. 24s. WAS AN AUTOF PERFORMED?	PSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC				1 _ YES 2 1 NO	COMPLETION OF CAUSE OF DEATH?
M					1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAL			IN 🗆	
0	26. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH (C	THER:		
₹	1 VES 2 NO 1 No 1 Nopelient 2 □ 27. MANNER OF DEATH 28e. DATE OF		Nursing Home 5 Residence		
	1 Natural 5 Pending (Month, Da		M 1 YES 2 NO	26d. DESCRIBE HOW INJURY	OCCURED
ВУ	2 Accident Investigation 3 Suicide B Could not be 28a. PLACE OF	INJURY — At home, term, stree		281, LOCATION (Street and Nui	mhar or Bural Bouta Mumhar
COMPLETED	4 Homicide detarmined building, a	tc. (Specify)		City or Town, State)	tracer or tracer tracer reactions
٣	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of a	TV knowledge death necurred of	the time data and place and d	to the extracted and extracted as	dad)
W	one) 2 MEDICAL EXAMINER: On the basis of axi	mination and/or investigation, in	my opinion, death occured at ti	e time, data end place, and due	to the cause(s) and manner as stated.
EC	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE N		DATE SIGNED (Month, Day, Year)
0	adam (Partz	M.D	P11-	143	December 24 1990
7	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	E OF DEATH (ITEM 27) (Type, Prin	0		Nicones of IIII
	Adam Clark 2	2 S. Green	6		
	31. DATE FILED (Month, Day, Year) DEC 2 8 1998 32. REGISTRAF	'S SIGNATURE 19.	parks		
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE  CAUSE  31. DATE FILED (Month, Day, Year)  32. REGISTRAE	2 S. Green	parks		Mcchel E1, 1991



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Shuck Samue December 24 0500 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON 14710 BYEES ROAD HAGERSTOWN If Under 1 Yaar | if Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthdey) 9. Birthplace (State or Foreign Country) Days Hours 10M 20 F 214-34-0829 Yrs. HAGEESTOWN, MA Usuai Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits HAGERSTOWN 1 ☐ Yes 2 No MD WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? POAD 14710 RYERS ZISA 21742 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN FARM. FARMER 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) SUSAN MARTIN HARRY. SCHUCK 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print TERRY L SCHUCK HAGERSTOWN MD 21742 14616 BYERS SON RD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 12 30 HAGERSTOWN, MLD 4 ☐ Donation 5 ☐ Other (Specify) HAVEN (EMETERY 22. Nama and Addrass of Facility MILLER-GROVE FUNERAL HONG 21. Signature of Funeral Service Licanses ntar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. GREENCASTLE PA Approximate Interval Between Onsat and Death Cardio vascular dispase Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 1 Yas 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

physician and the bunal-trans

this certificate has been signed by the attending rail director, page 2 should be detached for use at

funeral

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical.

To the Hosp within 24 hou To the Funer completely fil

g

Completed

Be

Medical

Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

ms 23a or death with

7 is marked other than "natural", or items treumstic event, the Medical Examiner m

nit. Pages 1 and 2 should be filed within 72 hours after or artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Item Injury or other traumatic event, the Medical Exercition

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

27. Manner of Daath

1 Natural 2 ☐ Accidant

3 Suicide 4 Homicide

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending

6 Could not be

28a. Date of Injury (Month, Dey Year) Investigation

28b. Time of 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28d. Describe how injury occurred

Certifying Phyeician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of south

29c. Licansa number

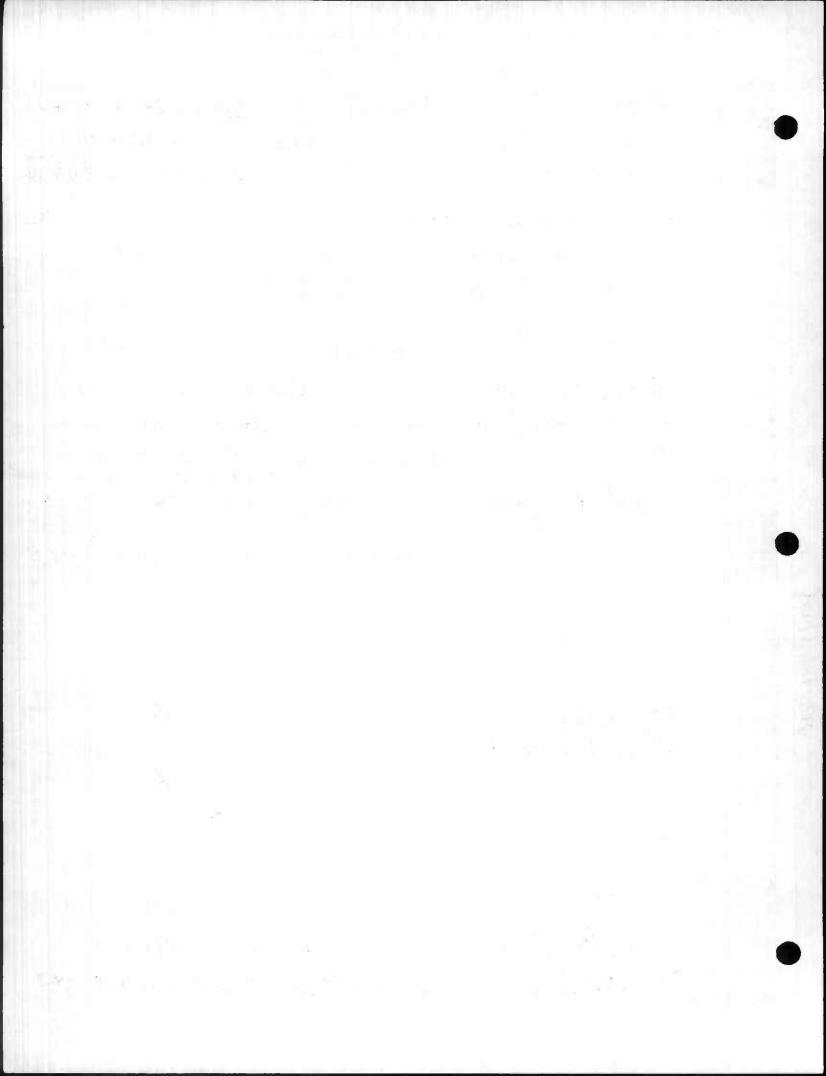
29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

no completed cause of death (Itam 23a) (Type, Print)

Hugestern MD 21742 31. Date filed (Month, Day, Year) 32. Registrarts Signature

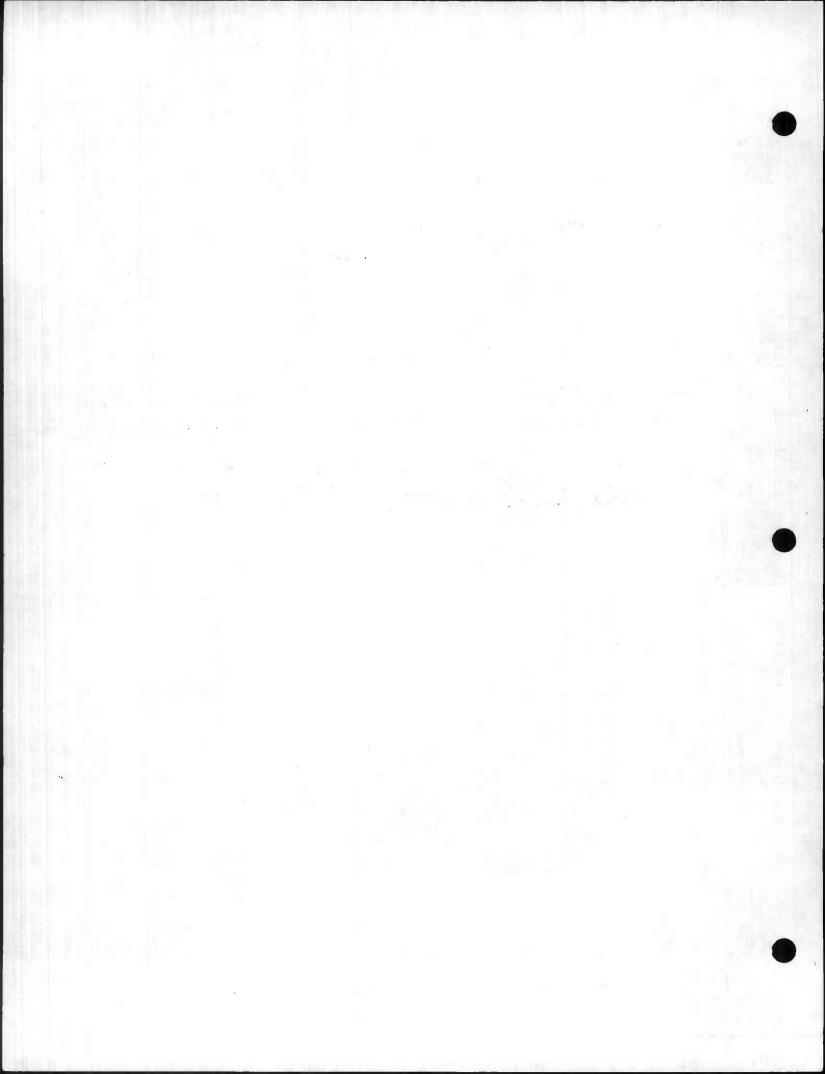
State Registrar



State of Maryland / Department of Health and Mental Hygiene

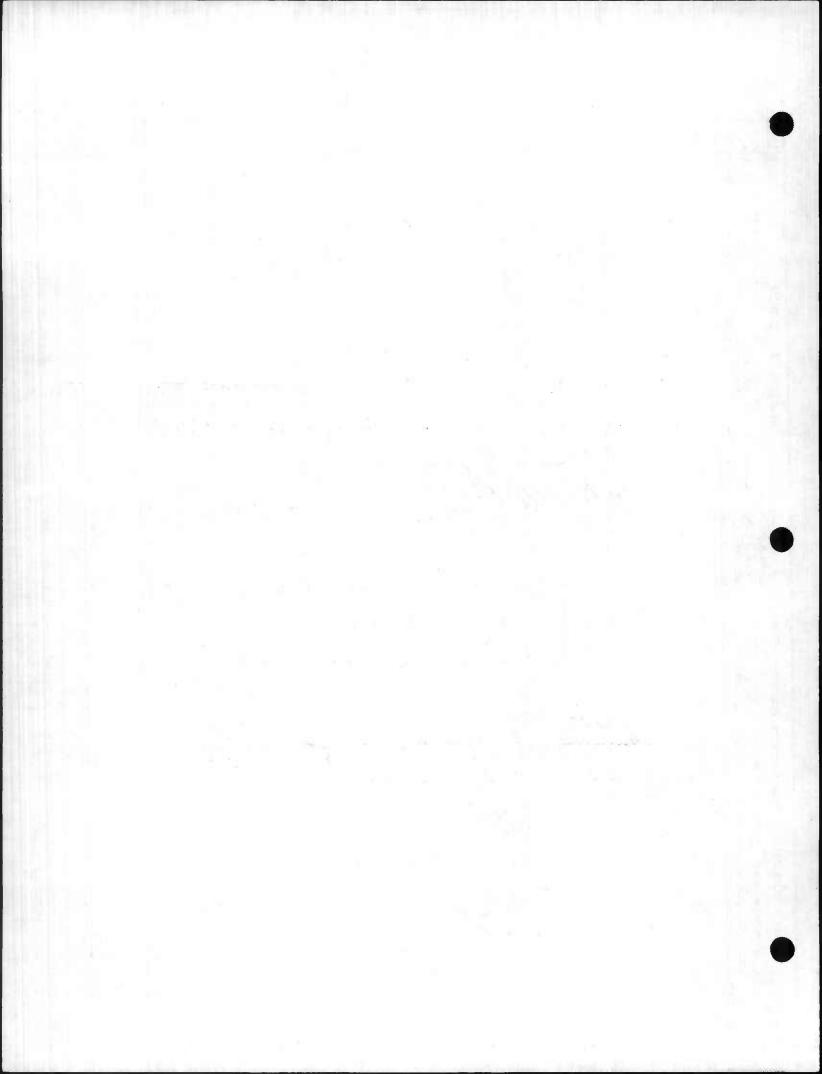
_	_				Certifica	ate of			Reg. No.	3 4	1205			
	Physician	Ualan	Last)		Si	ill		2. Date of De Month Dec.	Day	Year 1998	3. Tima of Death 8:30Am			
	/Medica Examine	to English blooms (Manch to sale story)		7)			4b. City, Town, or	Location of Death			U.JORIII			
		Salisbury Cente	er; Genesis	ElderCa	are		Salisb	ury, Md.	Wico	mico				
	Funeral Director	428-10-1619	6. Sex 1 □ M 2 ☑ F	ge (In yrs. last bi	Yrs. If Und Month	ler 1 Yeer s Days	If Under 24 Hr	s. 8. Dete of Bir	th ly, Year) 909		olace (Stale or Foreig otry) SISSIPPI			
	yland	Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	vn or Location					1	0d. Inside City Limit			
	death with the Maryland ms 23s or 28s-f show count be notified at	MD Wicomi	.co	Salisb	oury						1 □ Yas 2 🕅 N			
	with the or 20 and 10 a					Zip Code			10g. Citizen of t	What Coun	try?			
	fler death w r Herns 23a siner must b	201 Morris Drive	12. Wes Deceden	t Ever in U.S.		1804	Hispanic Origin? (	Specify Yes or No	- 14. Rec	USA e - Americ	an Indien.			
720	or he		Armed Forces	?		ecify Cub 2€ No		Specify Yes or No rto Rican, etc.)	Specify	ck, Whita,	etc.			
5	"netural",		Education	16a	. Decedent's U	ual Occu	pation	ortina	16b. Kind of Business/Industry					
7	withly been the	(Specify only highest Elementery/Secondary (0-12)	College (1-4or				during most of wo d)	NKIIY						
D	EIPE .	12 17. Father's Name (First, Middle, Li	ast)	Но	memaker		18. Mother's Na	me (First, Middle,	Domest Maiden Sumen					
la l	Mental Mental arked o		Alice M	ıllins										
Jar	and and and and and	19a. Informant's Neme/Reletionshi		iural Route Numb	er, City or Town,	Stata, Zip	Code)							
ָם ה	M Health Mem 27 i	Robert M. Still 20a. Method of Disposition	oury, MD		State									
altilliore	8057	1 ☐ Burial 2 ☐ Cremetion 3	20c. Location - City or Town, State											
	当時を記し	4 Donetion Statistics (Specify)  21. Signature of Funerel Service Licenses  Salisbury Crematory  22. Name end Address of Fecility												
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) (	Physician	23a 11. Enter the disease, or clock, or heart failure. List of	omplications that cause on each	the seeth. Do	not enter the m	OW H	ng, such es cardie	Sallsbur ec or respiratory a	rrest, MD 2	1804	Approximata Interval Between Onset and Deeth			
1	/Medical Examiner	Immedieta Cause (Finel disease or condition resulting In deeth) a.												
J.		Due to (or es e consequence of):												
	ansit	Sequentially list conditions.  Due to (or as a consequence of):												
,00700	icate be assouted physician and s the burist-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c											
-	5 0 4 -													
	the attending the death certified for use	Pert II. Other significant condition:	contributing to death	ven in Pert I.	23b. Dld	tobacco una co	ntributs to	ributs to the causs of death?						
	requires that the death cert een signed by the attendin- hould be detached for use- eted by Physician/M	ATM.			Yes 2 No	3 Prot								
	_ D 00 .T							24a. Was perfo	an autopsy rmed?	COL	ere eutopsy findings sllable prior to mpletion of cause death?			
	icien: The law certificate has t rector, page 2 a							10	Yes 2 No	10	Yas 20 No			
3	ysician: The I is certificata hi director, page	25. Was case referred to medical examiner?	11					eth (Check only o	one)					
5	this aldi		Hospitel: 1 Inpati	ury 28h	Time of Injury	28c. Inju Wo	*	Home 5 Resident	denca 6 Oth		v)			
NAIS!	To the Hospital or Attanding Physician 24 hours after death, completely filled in by the funeral Medical Certification: "Medical Certification:"	2 Accident investige 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	ijury - At home, fe tc. (Specify)			100 2010	28f. Location (: City or Ton		per or Rura	I Route Number.			
	Ne Hospital n 24 hours ne Funeral pletely fillec		Physician: To the best taminer: On the besis of and manner si	of examinetion an	e, death occurre d/or investigation	d et the ti	me, date end plac opinion, deeth occ	e, and due to the urred at the time,	cause(s) and mo	ennar as st and dua to	ated. the cause(s)			
1	within To the comple		2/1	1	2	9c. Licen:	se number		29d. Dete signe	d (Month,	Day, Year)			
		1/2/	ATU			05	934	9	12/2.	3/84	7			
	V	30. Neme and address of person wi	no completed cause of	death (Item 23a)	(Type, Print)		1-1-1		1					
		William H. Rob	ins, M.D	1104 F	HEALTHW.	AY DE	., SALISE	SURY, MD.	21804					
	State Registrar	31. Date filed (Mooth, Rey, Year) DEC 2 8 199	8 See	rer's Signeture	1 10		,							

DHMH 16 Rav 6/95



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryla		ificate of			g. No. 98	41206		
		1. Decedent's Nama (First, Middle, Last	)				2. Date of Deeth Month	Day Yea	3. Time of Death		
	Physician /Medical	Richard William					DECEMBER				
	Examiner	4a Facility Name (If not institution, giva	street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of De	eath		
		Sacred Heart Ho			the same of the sa	Cumberla		Allegan			
	Funeral Director	5. Social Security Number 6. Se 216-07-2303	7. Age (In yr. 88		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, 10-21-1		Birthplace (State or Foreign Country) ryland		
	h the Maryland r 28e-f show modified at	10a. State 10b. County		City, Town or Loca			MARCO O P		10d. Inside City Limits  1 Yes 2 □ No		
	or 28a-f a	Maryland Allegar	$\mathbf{x}$	esternp	ort 10f. Zip Code		100	- ON			
	with with				2156	2		g. Citizen of What (			
	fier death with the first state or stat	83 Spring Stree	12. Was Decedent Ever in	U.S. 13. W				nited S	merican Indian,		
21215-0020	urs after or iter	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	H.	es, specify Cub Yes 2∑[No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify: W	hite, etc.		
2-0	natural" natural"	15. Decedent's Edu (Specify only highast grad		16a. Decede	nt's Usual Occup	pation	ing 1	6b. Kind of Busines	ss/industry		
2	ed within 72 ho ygiene. er than "naturn ft, tre tredices Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use retire	during most of work d)	"9				
	Hygien there the Con	8		Genera	al Mecl	T			estvaco Corp.		
and		17. Father's Neme (First, Middle, Last)				18. Mother's Name			Channa		
Maryland	京を書き 戸			401 44 70	0.11	ł		Printy)			
Ma	0 4 4 4	19a. Informant's Name/Relationship (T)				and Number or Run					
-	1 and Health em 27	Betty Wright - ] 20a. Method of Disposition	Jaughter 206	Place of Disposit cemetery, crema	OOSEVE			Oc. Location - City	1D 21562 or Town, State		
Baltimore	Pages sent of I nt: If It iny or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ F	removal from State		· · ·		100				
Ė	교투를 등	4 Donation 5 Other (Specify)  21. Signature of Furieral Service Licens			rs Ceme	ecery   1 ess of Facility Fr			nport, MD		
Ba	Depa Impo any i	1. las HLV	1/1/2	/							
		23e, Part1. Enter the disease, or comp	lications that caused the of	PO not enter	Box 4				nia 26750		
Ŋ.	Physician	23e. Part1. Enter the disease, or compi shock, or heart feiture. List only o	ne cause on each line.						Interval Between Onset and Death		
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	Examiner	resulting in deeth)		for as a conseque							
ч	D # L		Acute	Myou	edial	Turano	how		/ das		
	cate be executed physician and the burial-transit dical Examiner	Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying	Due to	(or as a conseque	price of):				20/		
60,	ysician re buriel	Cause (Disease or Injury	Coronary	aste	ing A	searce			Ligeny		
68760	physicie the bur	thet initiated events resulting in death) Last	//-/	(or as a conseque	0						
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Box	ules that the death certification is greed by the attending to be detached for use and by Physician/Med						1				
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	5 80	Myly lens	cen				10.18	20/10 30	Processy 4 Ondiown		
Records,	been shoul	transton	of cell	Concu	our d	He Orner	24a. Wes an perform		b. Were autopsy findings available prior to completion of cause of death?		
Be	The law rate has the page 2 s	A Colonies of	1-7.1	3111111	B	4	1 □ Ya:	2 No	1 ☐ Yes 2 ☐ No		
Vital	certificate rector, pag	25. Was case referred to medical	HOU THE CA	many.	1, (1-	26. Place of Deat	h (Check only one				
	Physician: this certific ral director. I: To Be (	axaminer?	Hospitel: 1 Inpatient 2	☐ ER/Outpatient	3 DOA OH	hor		nce 6 Other (S	pecify)		
1 of	2 5 =	27. Manner of Deal	28a. Deta Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at	28d. Describe hor	w injury occurred			
0	Attending Ph or death. ector: After thi by the funeral	2 Accident investigation				Yes 2 □ No					
-	EFEC E	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, stree	t, fectory, office		28f. Location (Str. City or Town,		Rural Route Number,		
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	in 24 hours he Funer pletely fill edical	29a. Certifier Certifying Physical Control (Check only one) Medicat Exami	sician: To the best of my kr ner: On the basis of examinand menger-etated.	nowledge, death on nation and/or inve	ccurred at the til stigation, in my o	ma, date and place, opinion, death occur	and dua to the car red at the time, da	use(s) and manner te and place, and d	as stated. lue to the cause(s)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29b. Signature and titla of certifier)	San San San San San San San San San San		29c. Licens	se number	29	d. Data signed (Mo	onth, Day, Year)		
		11/1/1	Mha	40	1 /	3601		12/2:	3/98		
	5	30. Name and address of person who co	ompleted cause of death (Its	em 23a) (Type, Pr		0	4	1	/		
	nis	V. R. Felina M. D.	925 Rich	oblate	6 D	. Cambo	rland v	カカコル	502		
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	neture		1	, , ,				
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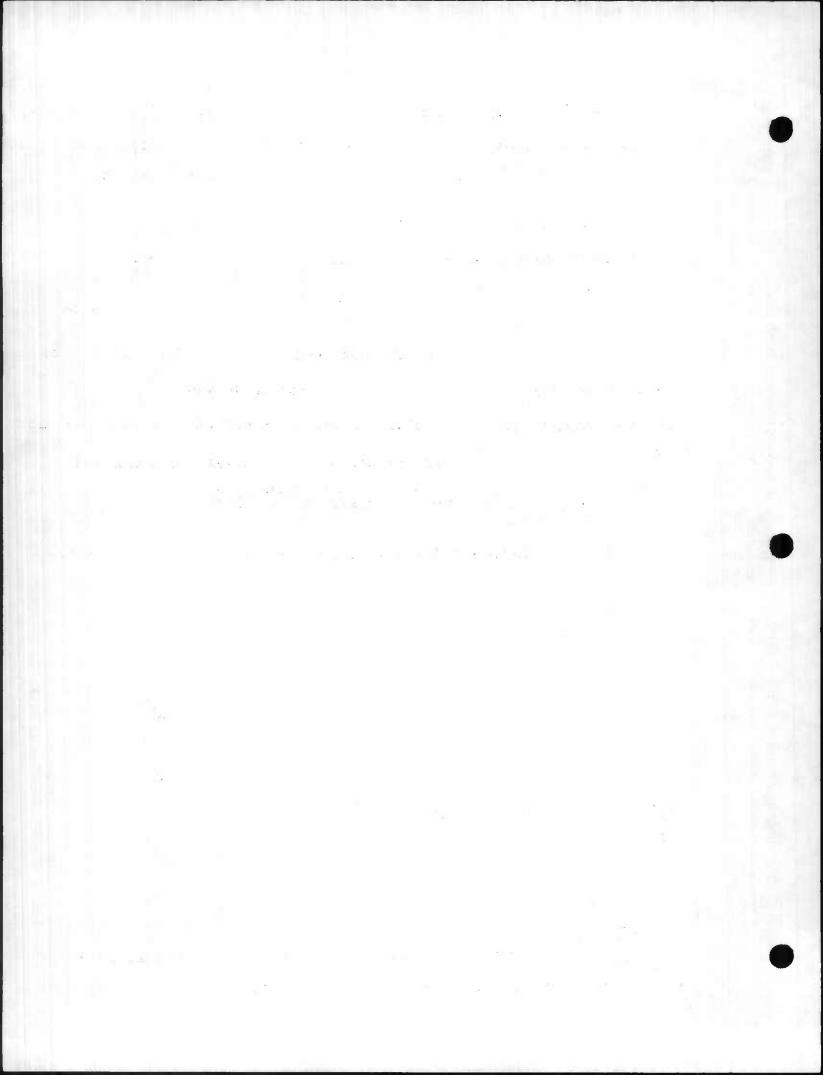


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month Dey Yee **Physician** Carl William Shipley S r Dec 24 1998 /Medical 10:30PM 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number, 4c. County of Deeth Examiner Memorial Hospital Cumberland
If Under 24 Hrs. 8. Dete Allegany
9. Birthplece (State or Foreign Country) 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) Dete of Birth (Month, Dey, Year) **Funeral** Min **№** M 2□ F Months Deys Hours Yrs. Director 212-38-7285 May 20, 1936 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Menyland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or frame 28 or 28a-f show any Injury or other traumatic avent, the Majore Examina. 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Flintstone MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12500 Murleys Branch Road NE 21530 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🎇 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentery/Secondery (0-12) College (1-4or 5+) Chief Maintenance Dept Natural Resources 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ira Owen Shipley Dorothy (Hymes) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joyce M. Shipley-wife 12500 Murleys Branch Road NE; Flintstone, MD 21530 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 N Buriei 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glendale Cemetery 12/28 Flintstone, MD 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Scarpelli Funeral Home, P.A. Cumberland, MD 21502
not anter tha moda of dying, such as cardiac or raspiratory arrest 23a. Pert1. Enter the disease, or complications that cause I he each, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Arteriosclerotic heart disease uk yrs disease or condition resulting In death) Examiner Due to (or as a consequence of) Examiner physician and the bunal-transit certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es a consequenca of): Box 68760 Physician/Medicai Due to (or es e consequenca of) 80 950 P.O. signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, b 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy periormed? completion of cause of death? page 2 s TO YOU NO NO 1 ☐ Yes 2 ☐ No certificata or Attanding Physician: director 86 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To Yes 2□ No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA this funeral 27. Manuer of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 1 × Neturel 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 10 Dpty Med Ex D 09157 Dec 24 1998 dress of person who complated causa of death (Item 23e) (Type, Print) 30. Nam Paul Snow, M.D. 124 w 3rd st Cumb Md 21502 31. Deta filed (Month, Dey, Year) DEC 2 9 1998 32. Registrer's Signature State

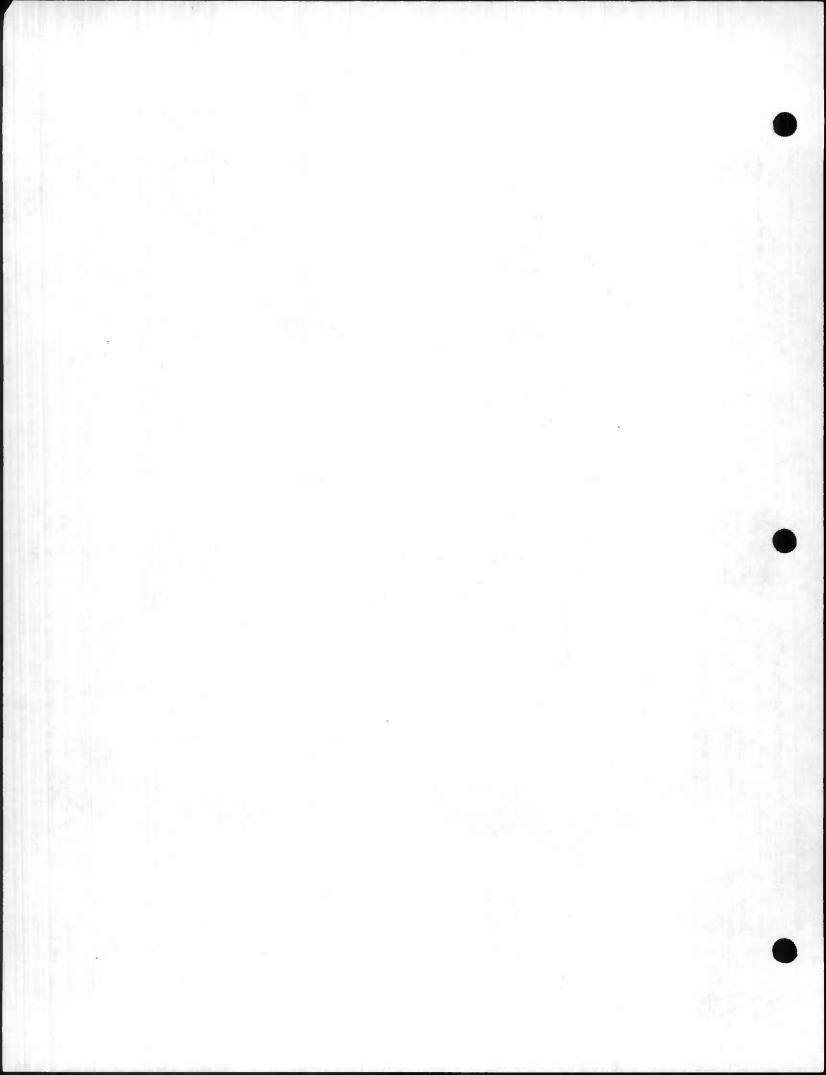
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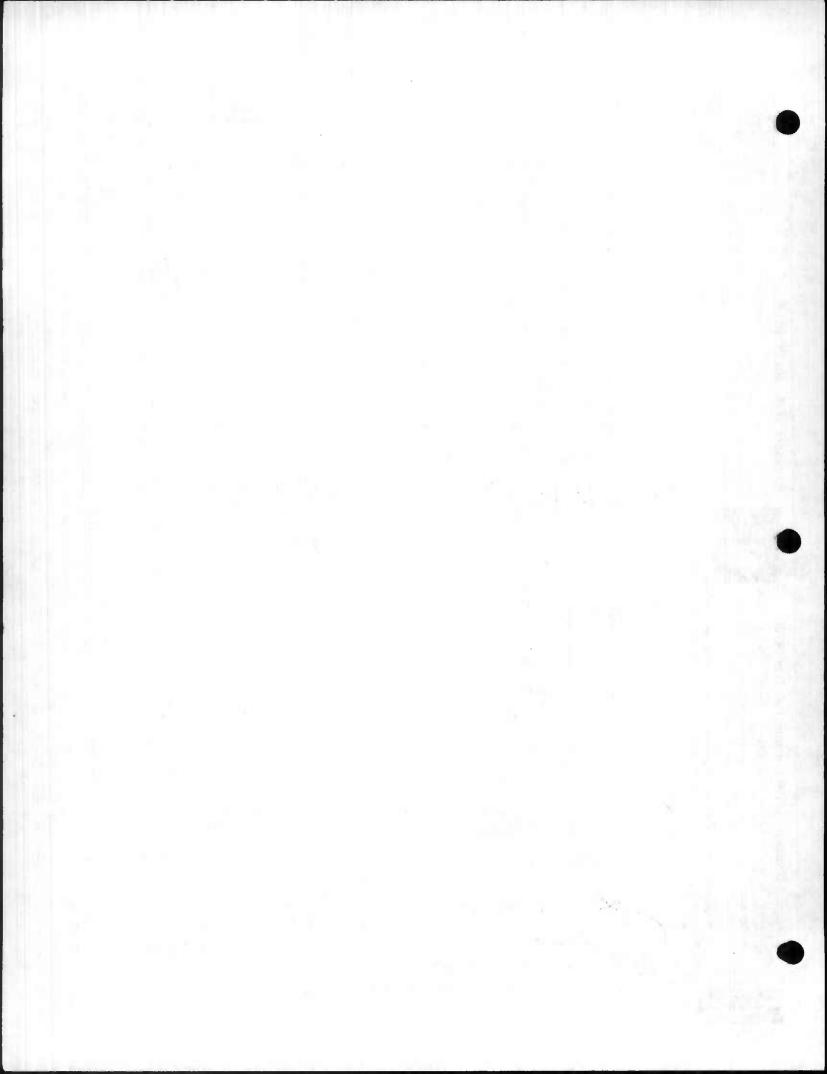
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	Funeral Director			M 2□F	(In yrs. last bi	Yrs.		Days		Min. J	Date of Birth (Month, Day, UNE 2.	Year) 190	6 WE	lace (State or Foreign (ry) St Va.
	pung Rau	-	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Tov	n or Loc	ation						1	0d. Inside City Limits
	Many	ò	Maryland Allegan	У	Cumb	erl	and							1 Yes 2 No
	with the Maryland a or 28e-f show be notified at	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of W	hat Coun	try?
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020	or Name	by Funeral	11. Merital Stetus  1 ☐ Never Merried 2 ☑ Merried  3 ☐ Widowed 4 ☐ Divorced	2. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:			Ves Deced Yes, spec		lispanic Origin an, Mexican, F Specify:	n? (Specif Puerto Rid	y Yes or No- an, etc.)	14. Rece · American indian, Black, White, atc. Specify: White		atc.
ğ	n 72 hours		15. Decedent's Educ	ation	16a	. Decede	ent's Usue	Occup	ation		1	6b. Kind of Bus	Business/Industry	
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2	od vi	00			,	ruc	k Di	cive			Baking Company			
Maryland 21215-0020	tal do y	e e	17. Father's Neme (First, Middle, Last) Charles C. Ste	wart						s Name (First, Middle, Meiden Sumame) ephine Batt				
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Baitimore,	Department of important: If eny injury or page.		21. Signature of Funeral Service License  Emg A A , Rule	// /		LOWY			SEETHY		eral F		30 E	Baltimore
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	the etter	Physician	Pert II. Other significant conditions con	ributing to death but	not resulting i	n the un	derlying ca	use giv	en in Part I.		23b. Did tol	oacco uss con	tributa to	the cause of death?
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Ö	Attending r death. ector: Afte by the fune	SALVE	2 ☐ Accident investigation			,	М		Yes 2□No	0				
Division	or Attendent of Director in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, la (Specify)	arm, stre	et, fectory	, office		281	Location (Str. City or Town,		or Aura	I Route Number,
0	ors al													
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the called one of manner stated.									ated. the cause(s)			
	othe omple		29b. Signeture and title of certifier	O'TO ITIAI III O' PLATE			29c	. Licens	e number		29	d. Dete signed	(Month,	Dey, Year)
	F3F85		1 Draw	1 les	1			D	318	5			26	
	4.0	-	30. Name and address of person who cor	peteled cause of dea	th (Item 23a)	(Type. P	Print)		310		D.	ECEMBER	, , ,	, 1998
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ral lor	5. Sociel Security Number 6. S 220-26-7689	7. Age (In	yrs. lest birthday) Yrs.	If Under 1 Year Months Deys		8. Date of Birth (Month, De) MARCH 2	7, Year) 2 1931	9. Birthpl Count MARY	lace (State or try) LAND		
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io	MARYLAND ALL	EGANY	CUMBERL	AND					1 X Yes 2		
Director	10e. Street end Number			10f. Zip Code			10g. Citizen of	What Count	try?		
	48 MARION STREET			2150			U.S.A	•			
by Funeral	11. Maritei Stetus  1 ☐ Never Merried 2 ☐ Married  3 ☐ Widowed 4∑Divorcad	12. Wes Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates:KOF		Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🕅 No	Hispenic Origin? (Spen, Mexicen, Puerto Specify:	pecify Yes or No- Rican, etc.)		e - America ok, Whita, e v: WHIT	etc.		
eted	15. Decedent's Ed (Specify only highest gre-	ucetion de completed)	18a. Deced	lent's Usuel Occup	petion during most of work	cina	16b. Kind of B	usinass/Ind	lustry		
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	ANNA MAE RANDALL	COMPANION			EET CUMBE						
	20e. Method of Disposition	20	b. Place of Dispo	sition (Name of netory or other ple		Date	20c. Location -				
	Mainal 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from State				29 199	8 FLINT	STONE	MD.		
	ROCKY GAP VET CEMETERY DEC 29 1998 FLINTSTON  21. Signeture of Funeral Service Licenses  22. Name and Address of Facility  MERRITT-ADAMS FUNERAL HOME										
	Tolo &	Part			AMS FUNER		AND MAD	777 A 375			
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Completed by						24a. Was a perfor	n autopsy med?	con	ra autopsy fine llebie prior to apletion of cau		
E						1 🗆 Y	es No	10	Yes 2□ N		
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cati	2 Accident investigation				Yes 2 □ No						
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×	29b. Signeture and titia of certifier			29c. Licens	29c. License number 29d. Dete signed (Month, De				ley, Year)		
	XX a XX		D 09159 DECEMBER 26, 1998				1998				
	11/0/2							- ,			
Medical Cer	30. Name end eddress of person who co	ompleted cause of death (	Item 23a) (Type, F	Print)							

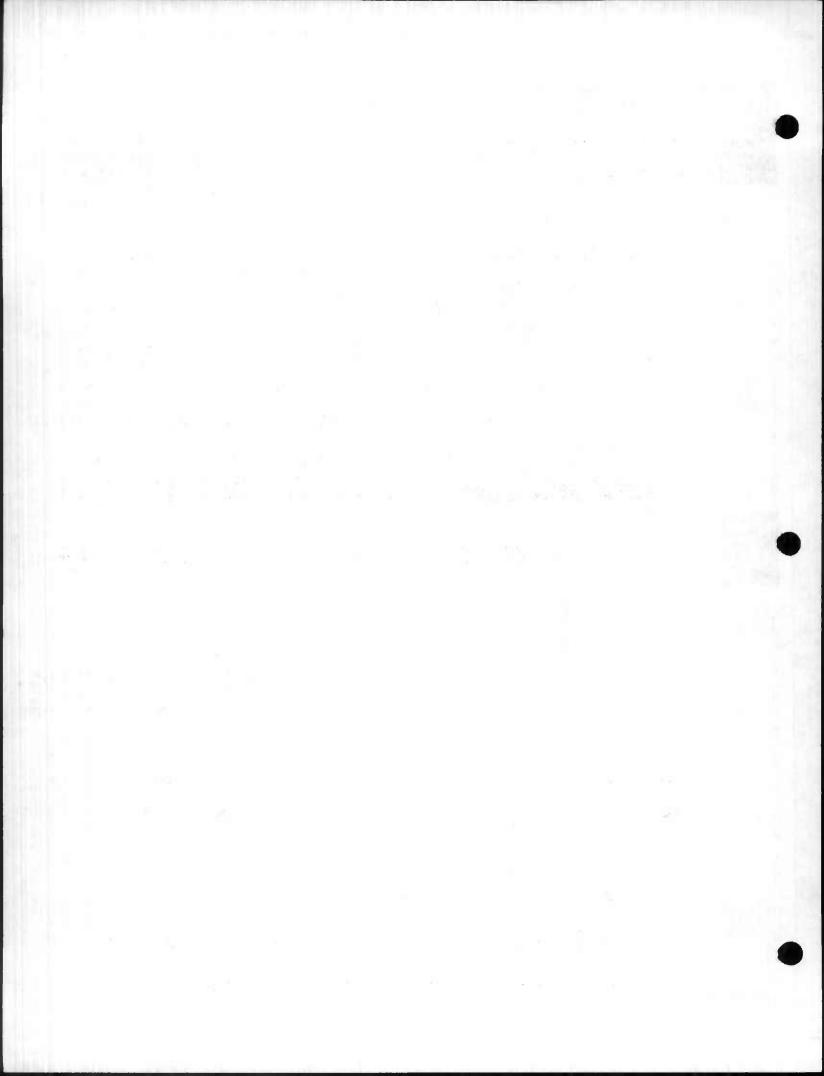
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State of Maryland / Department of Health and Mental Hygiene

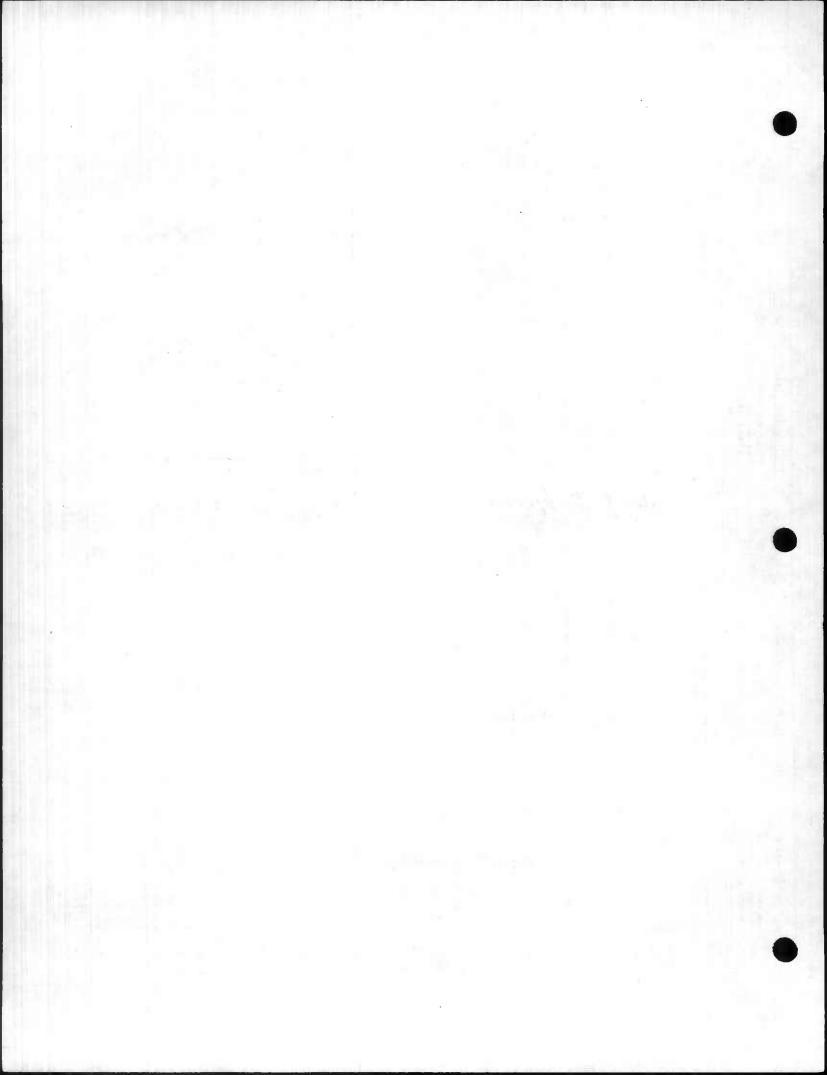
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A 11		10a. State 10b. County		10c. Cit	y, Town or Loc	cation				100	d. Inside City Limits	
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0 0	To B	Harry	Ε.	Sa	anford	l	Ethe	21	Gi	Gilbert		
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4		Mary Elizabeth	h Sanfor	d	66	W. C	college A	ve. Fros	tburg,	Md.	21532	
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DHMH 16 Rev 6/95



DHMH 16 Ray 6/95

State Registrar 32. Registrar'a Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Clise Simms 12 1:00 pm 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth H Under 1 Year If Under 24 Hrs. 8. Bete of Birth Months Deys Hours Min. 05 - 17 Egle Nursing Home Allegany 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 10 M 200 F 80 579-22-4003 Yrs MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany 1 ☐ Yes 2 No Frostburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11515 Kenner Lane S.W. 21532 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Orlgln? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Nidowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) John Henry Clise Tinnie Beeman 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21532 19a. Informant's Name/Relationship (Type, Print) Mary Ann Kenner Niece 15119 New Georges Creek Road, S.W., Frostburg, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dec. 22 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Grove Methodist Cemetery Aylor, VA 4 ☐ Donation 5 ☐ Other (Specify) 1998 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Eichhorn-McKenzie Funeral Home P.A. 23e. Pert1. Enter the disease, or compléctions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. 23e. Pert1. Enter the disease, or compléctions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Interval Betwe Onset end Deeth Immediete Ceusa (Finel diseese or condition resulting in deeth) ARILY 10 YEAR Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 450 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes en autopsy performed? CHRONIC ORSTRUMINE LUNG DUEASE completion of cause of death? Vascula 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? 26. Plece of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. injury et Work? 28d. Describe how injury occurred 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be axecuted been signed by the attanding physician and should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical certificata has or Attending Physicien: this After r death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Items 23s or 28s-f show

Director

Funeral

Completed by

MD

Pagas 1 and 2 should be filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

permit. Pagas 1 and 2 should be filed within 72 hours aftar de Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or item any injury or other traumetic event, are Medical Examines.

**Physician** 

/Medical

Examiner

P

Completed

Be

2

Certification:

Medical

Pert ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

6 Could not be determined

Heale

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one)

3 ☐ Suicide

4 Homicide

124 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number 26907 29d. Dete signed (Month, Dey, Year) DECEMBER

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

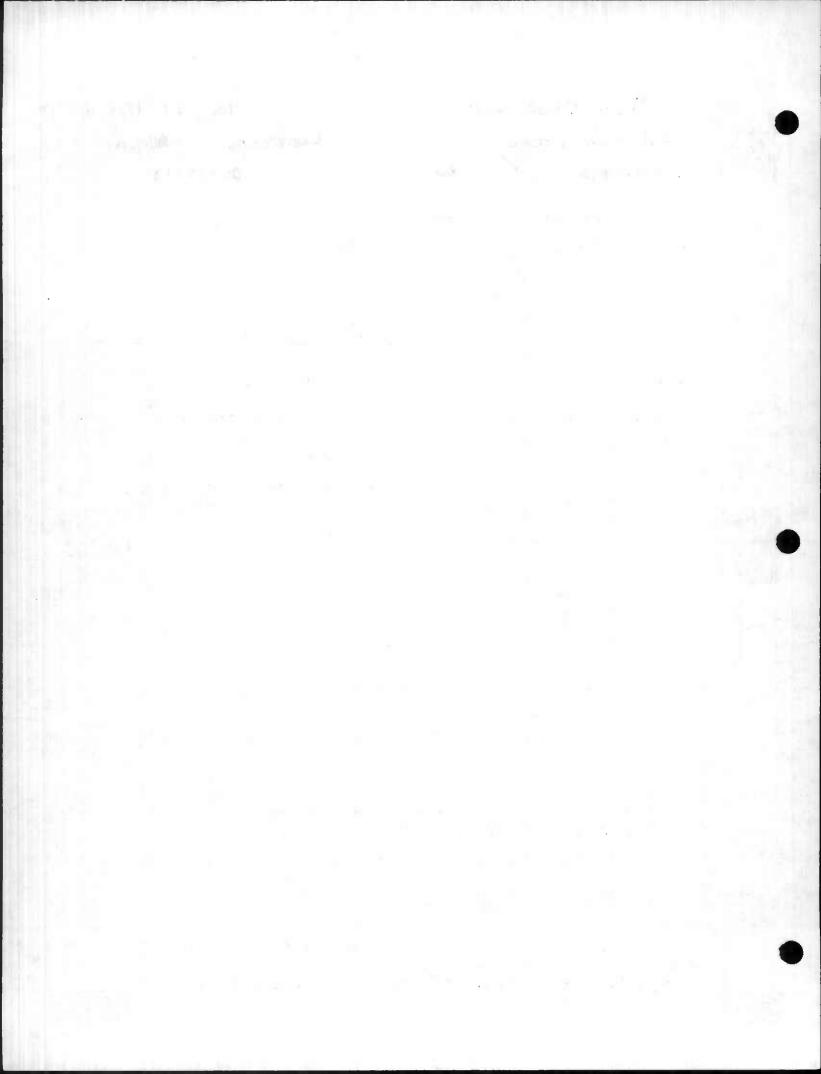
Harjit S. Sidhu 925 Bishop Walsh Road, Cumberland, MD 21502 31. Dete filed (Month, Dey, Year)
DEC 2 1 1998

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

State Registrar

MI

32. Registrer's Signeture



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥄 Certificate of Death 2. Dete of Deeth

3	Physician /Medical
	Examiner
4	
1	Funeral

1. Decedent's Neme (First, Middle, Last) 3. Time of Death Dec 16, 1998 11:45 AM George Marvin Smith 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death 7200 Kipling Parkway District Heights Prince George's | Hunder 1 Yeer | Hours | Min. | 8. Dete of Birth | Month, Dey, Year, March 25, 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Year) 1₩ 2□F 577-22-9147 74 Yrs. 1924 WashingtonDC Director Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits 28a-f show 7 is marked other than "naturel", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be incurred as 1□ Yes 2⊋No Director P.G. District Heights 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7200 Kipling Parkway 20747 United States pemit. Peges 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a any injury or other traumatic event, the Medical Experies mass 2006. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bieck, White, etc. Yes 2 No NYes, Give Yeer or Detes: 1 □ Never Merried 2 □ Merried 1944 Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: Specify: White by ₩idowed 4 Divorcad 1959 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Ist Sgt. U.S. Air Force 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Ella Burdge Munsetter Charles Edward Smith 19b. Meiling Address (Street end Number or Rural Route Number, Clfy or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Charles R. Smith (SON) 2220 South Lumber Street, Allentown, Pa. 18103 20b. Piece of Disposition (Name of cemetery, cremetory or other place) Dec 23, P998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington , Virginia Arlington National Cemetery 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old 21. Signature of Funeral Service Cicens Alexandria Ferry Road, Clinton, Maryland 20735 Fig. 1. Enter the disease, or amplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Onset end Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Cardio- Pulmonary Arrest Examiner Due to (or as e consequence of) Examine Lung Cancer thet the death certificete be axecuted physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ottending p signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by The lew requires 24b. Were autopsy findings available prior to been si Completed 24e. Wes an autopsy performed? completion of cause of death? il director, paga 2 s 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5XXesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dev Year) After XXNeturel 5 Pending death. Investigetion 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / d in by the i 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide hin 24 hours af the Funerel Di npletaly filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

20+1

State Registrar Sattva Swarup Neelapu, 8901 Wisconsin Ave, Bethesda, MD 20889 32. Registrer's Signeture DEC 2 2 1998 >

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NNMC, Bldg 8 3RD Floor

V. S. Swarup

D0052965

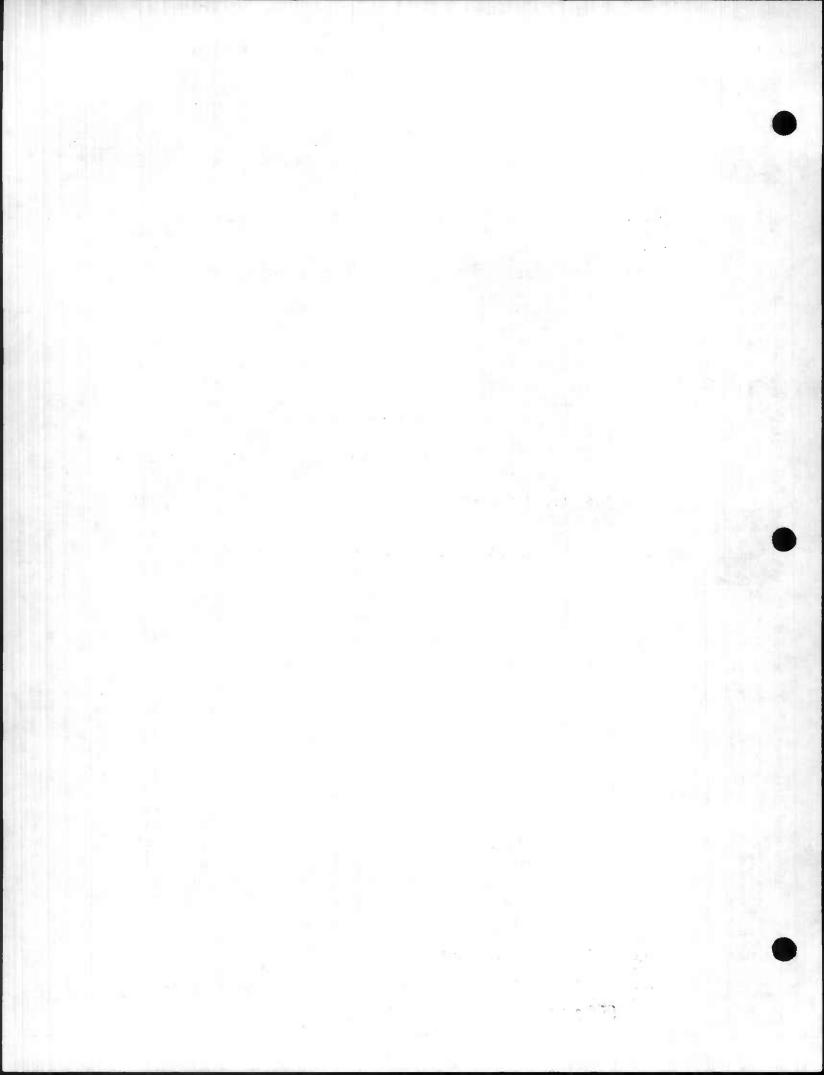
Dec 16, 1998

**DHMH 16 Rev 6/95** 

Free Public of Division Line r 

State of Maryland / Department of Health and Mental Hygiene 8 4 2 4

						Ce	rtificate	of	Death		R	eg. No.	-6	I fice I T
я	Dhuaisia	_	1. Decedent's Neme (First, Middle	, Last)						2.	Data of Deal Month	th Dey	Year	3. Time of Death
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	Examine	_	4a Facility Name (If not institution	give street and num	iber)				4b. City, Tow	wn, or Locat	ion of Death	4c. County		
		Ś	5547 HILLMAR DRI	VE				F	ORREST	IVILLE		PRINC	E GEO	ORGES
	Funeral Director		5. Social Security Number 213 21 7378	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 2	last birthday,	Months	1 Year Days	If Under 2 Hours	Min.	Data of Birth (Month, Day, eb 5,	Year) 1971	9. Birthp Court Wash	place (State or Foreign stry)  D.C.
	p ,	-	Usual Residence of Decedent  10a. State 10b. County		100 00	Town and								044 14 00 41 0
	eho eho	2			TOG. CR	y, Town or L		Oh-		les De	la			0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-f show	Directo	Maryland Cal	ert			-		sapeal	ke bea				4.5
	= 0.4	a Di	10e. Street and Number 7626 C Street				10f. Zip (	207	32		'	0g. Citizen of USA		itry?
020	urs after	by Fur	11. Marital Status  1 □ Never Married 2 ☑ Merri 3 □ Widowed 4 □ Divorced	12. Wes Deceded Armed Formation 1 Tyes of the Year or Da	ces? 2 No	,S. 13,	Wes Decede If Yes, specif		lispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		ck, White,	
5-0	72 ho	9	15. Decedent (Specify only highes	a Education		16a. Dece	dent's Usual	Occup	ation	of working		16b. Kind of B	6b. Kind of Businass/Industry	
21215-0020		Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use	e retire	d)	Of Working				
	ntei Hygid ed other event, is	Bec	17. Father'a Name (First, Middle, I	ast)					18. Mother	r's Neme (F	irst, Middle, I	Meiden Suman	ne)	
Maryland	should by the state of the stat	0	John Franci	s Gri	.m				Car	ol	Ann	Shi	civer	44.
ary	d 2 should th and Men T le marke traumatic		19a, Informant's Name/Relationsh	ip (Type, Print)		19b. Mail	ing Address (	(Street	and Number	r or Rural R	oute Number	, City or Town	State, Zip	Code)
Σ			Carol A. Grim	' mother		same	as #	10	above					
re,	of Health Nem 27 r other tr		20a. Method of Disposition			Place of Disp	osition (Name	e of	20)	0	Date	20c. Location	City or To	wn, Stata
Baitimore,	2 2 2		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		tate		11 Cem			12-	18-98	Suitl	and.	MD
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		+	23a. Pert1. Enter the disease, or shock, or heart lailure. List of	complications that ca	used the deat						P.A.,		js, ri	D 20736 Approximete Interval Between
	Physician /Medical Examiner	101	Immediate Cause (Finel disease or condition resulting in death)	. Mu	tip (e	or as a conse		ho	+ [	Noc	inds	3	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Onset and Death
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Records,	een signed hould be det	6									24a. Was a	n autonsv	24b. W	ere autoosy findings
Ö	been s	Completed									perform	ned?	CO	ere autopsy lindings allable prior to mpletion of cause
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Division	or A		4 Homicide determin	100 PINCO	of Injury - At he g, etc. (Specif	ome, remn, st	reet, tectory,	Office	015	417 11	City or Town	n, Stele)	oer or Hurs	at Route Number,
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		-	29b. Signature and title of certifier	and manne	SIBIOG.		200	Licens	e number		1 9	9d. Date signe	d (Month	Day Yearl
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	4	-	J. Per	oner,	1.1.0	,							,	
		1	30. Name and address of person v	ho completed cause										
			31. Date filed (Wonth, Day, Year)	IVACI	111 1	Penn S	treet,	Ba	ltimo	re, Ma	arylan	1 21201		
	State		31. Date filed (Worth, Day, Year)	1 1998 D	gistrar s Signa	TUP	6	1	77					
	Registra		DLU Z	1330	Carper.	/	9. 1	00	Kal					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DEC 22 1998 5:01 PM ALI PASHA SHOUKAT /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-24-24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours MM 20F 73 Yrs Director 226-81-0454 Pakistan Usual Residence of Decedent the Meryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, ma Mooical Examinat mant be notified at Director 1 DeYes 2 □ No VA. Fairfax Springfield 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8622 Arley Dr. 22152 Pakistan Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 72 hours eftar 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify:Pakistani by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchant Unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Peges 1 and 2 should be fi Depertment of Health and Mental F important: If Item 27 is marked ott any injury or other traumatic ever Be 2 should be fi and Mental H Muhammad Ali Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mahmood Shoukat 8622 Arley Dr. Springfield, Va. 22152 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-28-98 Lahore, Pakistan Family Cemetery 4 □ Donetion 5 □ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility UNIVERSAL MORTUARY INC. 411Kennedy St, N.W., Wash, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death **Physician** /Medicai fmmediate Cause (Finel disease or condition resulting in death) CORONARY ARTERY DISEASE Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated executions) Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting In death) Last Due to (or es e consequenca of): 88 9SF Por Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen hes page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Pleca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DFCEMBER 23, 1998 GFE 79711 (CA) NATIONAL NAVAL MEDICAL CENTER 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Daniel L. Gramins, LT, MC, USNR BETHESDA MD 20889-5600 31. Date filed (Month, Day, Yeer)
DEC 2 4 1998 32 Registrar's Signature State Registrar - Consulto

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State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** DECEMBER 17th 1998 JAMES K. SULLIVAN /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner MONTGOMERY COLLINGSWOOD NURSING & REHABILITATION CTR. ROCKVILLE if Undar 1 Year if Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1XXM 2□ F 573-36-1122 Yrs. Director Sept. 13, 1921 Texas Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inaide City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiene. Important: If them 27 is marked other than "natural; or flerms 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified as 1 Nas 2 No Director P.G. Glenarden 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 8619 Glenarden Pkwy. 20706 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaer or Datas: 1 ☐ Nevar Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2t No Specify: White þ 31 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 2vears Not given Not given 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be 2 Not Given Not given 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8619 Glenarden Pkwy, Glenarden Md. 20706 Courtney Hewlett/Guardian 20b. Plece of Disposition (Nama of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cem 1/5/99 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Va. 21. Signature of Funarai Sarvice Licensee 22. Nema end Addrasa of Facility Johnson & Jenkins Inc, 716 Kennedy St. N.W. Wash. D.C. 20011 23e. Part1. Enter tha diseese, or commanded, or heert feilura. List only Approximata Intarval Between Onset and Deeth ons that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical immediate Cause (Final disease or condition resulting in death) hour MYOCARDIAL INFARCTION Examiner Due to (or es a consequence of) physician and s the burial-transit that the death certificate be executed Sequentielly list conditions, if any, leeding to immediata cause. Enter Undarlying Cause (Disaase or injury that initieted events rasulting in deeth) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 980 0 Pert il. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t d be detach 3 Probably 4 Unknown 1 Yes 2 No CVA, ARTHRITIS, DEMENTIA, HTN þ should 24b. Wera autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed : has t Tes 24 No TLIYes 2E-No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Value Nursing Homa 5 Rasidence 8 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Motural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, etreet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Centrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Physicia D000033556 December 17, 1998 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Sharefield enton mo 20878 Road

State Registrar

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ANNE ARUNDEL MED 5. Social Security Number 6.	TEWART  Ive street and number)  PICAL CENTER  Sex 7. Age 1	(In yrs. last birtho 95 Yrs 10c. City, Town o EDGEWA	Months Days  r Location	4b. City, Town, or L ANNAPOLI If Under 24 Hrs. Hours Min.	ocalion of Death	Day ER 15, 1 Ac. County ANNE	ARUN  9. Birthp	3. Time of Death 1350  DEL COUNTY lace (State or Foreign intry) INGTON DC
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(Specify only highast gi	Tour Or Dates.		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		Rican, atc.)	Black Specify:	k, Whita,	
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that initiated events resulting in death) Last	C	ua lo (or as a con	sequence of):					
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	miner: On the basis of a:	xaminetion and/o	eeth occurred at the tie r invastigation, in my c	me, date and place, opinion, death occur	and dua to the red at the time,	cause(s) and ma data and place, s	nner as s and due to	tated. the cause(s)
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30. Name and addrass of person who	complated causa of dea	ith (Item 23a) (Ty	pe, Print) Accal PK	ing Acu	uppoles,	102	. Ye	2/
31. Data filed (Month, Day, Year)	82. Registrer	s Signatura		U.				
	LILLO V. McKENNEY  19a. Informant's Name/Relationship  JUNE E. SPRADLIN,  20a. Method of Disposition  1	19a. Informant's Name/Ralationship (Type, Print)  JUNE E. SPRADLIN, DAUGHTER  20a. Method of Disposition  1	LILLO V. MCKENNEY  19a. Informant's Name/Ralationship (Type, Print)  JUNE E. SPRADLIN, DAUGHTER  20a. Method of Disposition 1	192. Informant's Name/Relationship (Type, Print)  193. Informant's Name/Relationship (Type, Print)  194. Mailing Address (Street  2923 MAIN STY  292. Method of Disposition 1	LILLO V. MCKENNEY  19s. Informant's Name/Relationship (Type, Print)  JUNE E. SPRADLIN, DAUGHTER  20a. Method of Disposition  10 Buriel 2 Clicamation 3 Removal from Stata 4 Donation 5 Other (Specify)  21. Signature of Fungral Service Liceopee  12. Nama and Address of Facility  FORT LINCOLN CEMETERY  22. Nama and Address of Facility  FORT LINCOLN FUNER  3401 BLADENSBUPG RI  23a. Parti. Eriler the diseasa, or complications their consecutions on each line.  Immediata Causa (Final diseasa or conditions, if any, leading to immediate causa. Eritar Underlying cause from the or consecution of the print of	Sequentially list conditions cause final disease or original death of the sequence of cause final resoluting in death of the sequence of cause final resoluting in death of the sequence of cause or injury death or injury death of cause or injury death or injury	BLANCHE E. TREAKLE	BLANCHE E. TREAKLE  19a. Informant's Name-Palationship (Typa, Print)  19a. Informant's Name-Palationship (Typa, Print)  19b. Mailing Address (Sireet and Number or Rural Routs Number, City or Town, State, Zep  20a. Method of Disposition  1 dispurie 2 Discussion 3   Removal from State 4 Clocanation 5   Contesting-Point 1   20b. Heave of Disposition (Name of Disposition)  1 dispurie 2 Discussion 3   Removal from State 4 Clocanation 5   Contesting-Point 5   20b. Heave of Disposition (Name of Disposition)  1 dispurie 2 Discussion 3   Removal from State 4 Clocanation 5   Contesting-Point 5   20b. Heave of Disposition (Name of Disposition)  1 dispurie 2 Discussion 3   Removal from State 4 Clocanation 5   Contesting-Point 5   20b. Heave of Disposition (Name of Disposition)  2 disposition 5   Contesting-Point 5   20b. Heave of Disposition (Name of Disposition)  2 disposition 5   Contesting-Point 5   20b. Heave of Disposition (Name of Disposition)  2 disposition 5   Contesting-Point 5   Cont

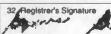
DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent'e Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** Sula xott December 22,1998 12:24 p.m. /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Airy Pleasant View Norsing Home Carroll W.F. 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 100 Yrr | Months | Days | Hours | Min. 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign Country Haynesville 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 KF 487-28-1314 100 Yrs. Director 19, 1898 Louisana Usual Rasidence of Decedent Manyland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "netural", or itema 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at Maryland Prince George's Suitland 1 X Yas 2 □ No Director 200 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3908 Stonegate Drive, Apt # B 20746 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcea? 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 X No if Yes, Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: px 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "nath any injury or other traumatic avent, the Marice page. Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 6th 17 Fathar's Nama /First Middle Last) 18. Mothar's Nema (First, Middle, Maiden Surnama) Be Monroe Henderson Mary Henderson 19a. Informant'a Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Harry J. Scott/Grandson 3908 Stonegate Drive, #B, Suitland, Maryland 20746 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from Stata Harmony Memorial Park 1998 4 Donation 5 Other (Specify) Landover, Maryland 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME Nancu Vence 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the office se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting In death) CHROIAC Arrest Minules Examiner Due to (or as a consequence of): Examiner CARDIAC ATHEMSCIEMSIS attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): (several eur Box 68760. theroscherose Physician/Medical Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 6 Ce rebral viscular accident. Dementia à 24b. Wara autopsy findings available prior to completion of cause of death? Completed Atreal Jehrellaton 24a. Was an autopsy performed? Deen Sec 20 No 1 Yes 2 No certificate 1 Yas Physician: 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Certification: To this 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? To the Hospital or Attanding P within 24 hours after death.
To the Funeral Director: After it 1 Natural 5 Pending invastigation 1 TYas 2 TNo 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Sulcide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. edical 29e. Certifier completely (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number Melu foel Kordm ms D06588

State Registrar

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) 4801 DOTSEY HALL BYIVE ELLUSTICITY 31. Data filed (Month, Day, Year) DEC 2 3 1998





Mary land

21044

D. Santo

€6 8 2 330

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Anna Mary Elizabeth Millender Tracey 18, Dec 1998 3:15 am /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 4017 Shiloh Avenue Hampstead Carroll 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1□M 2□F Yrs. 220-01-2230 85 **Director** Sep 27, 1913 Maryland Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen nent of Heelth and Mental Hygiene. sht: If item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other traumetic event, its Maxical Examines must be notified. Maryland Carroll Hampstead 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4017 Shiloh Avenue 21074 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ≥ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3√ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11 18. Mother's Neme (First, Middle, Malden Surname) 17. Father's Neme (First, Middle, Last) Be Annie Elizabeth Ruby Daniel Howard Millender 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Betty Bollinger, daughter 1611 St. Paul St, Hampstead, MD 21074 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donetton 5 Other (Specify) permit. Page Department of Important: If eny injury or 12/21 Hampstead Cemetery Hampstead, MD 22. Neme end Address of Fecility 21. Signature of Funeral Service Licenses Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Metastatic Adenocarcinoma 1 month disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner ettending physicien end for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert ii. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed' ate hes page 2 : 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 28e. Dete of tnjury (Month, Dey Year) 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 6 Could not be determined Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) and menner as stated. | Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi

State Registrar 31. Dete filed (Month, Dey, Year)

DEC 2 2 1998

Steven Shaffer

30. Neme and address of pe

bon who completed cause of death (Item 23a) (Type, Print)

Lather 211 However Pite (ear)

32. Registrar's Signeture

G. Sparks

33165

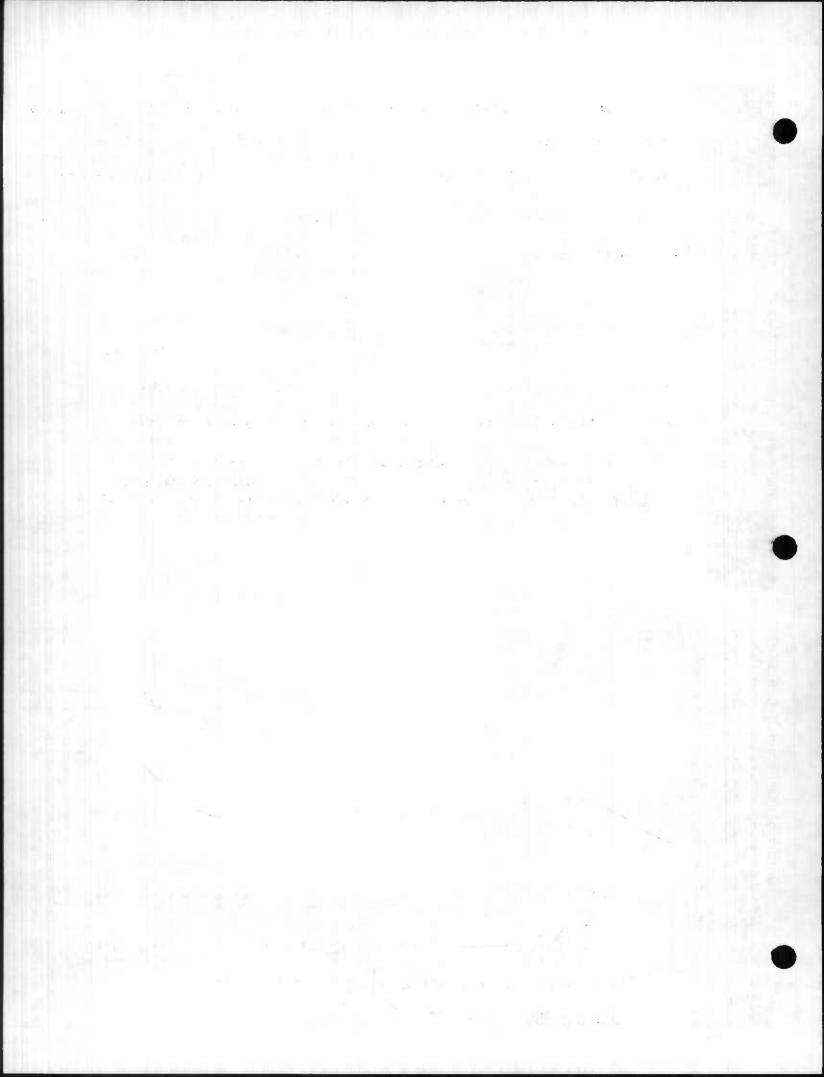
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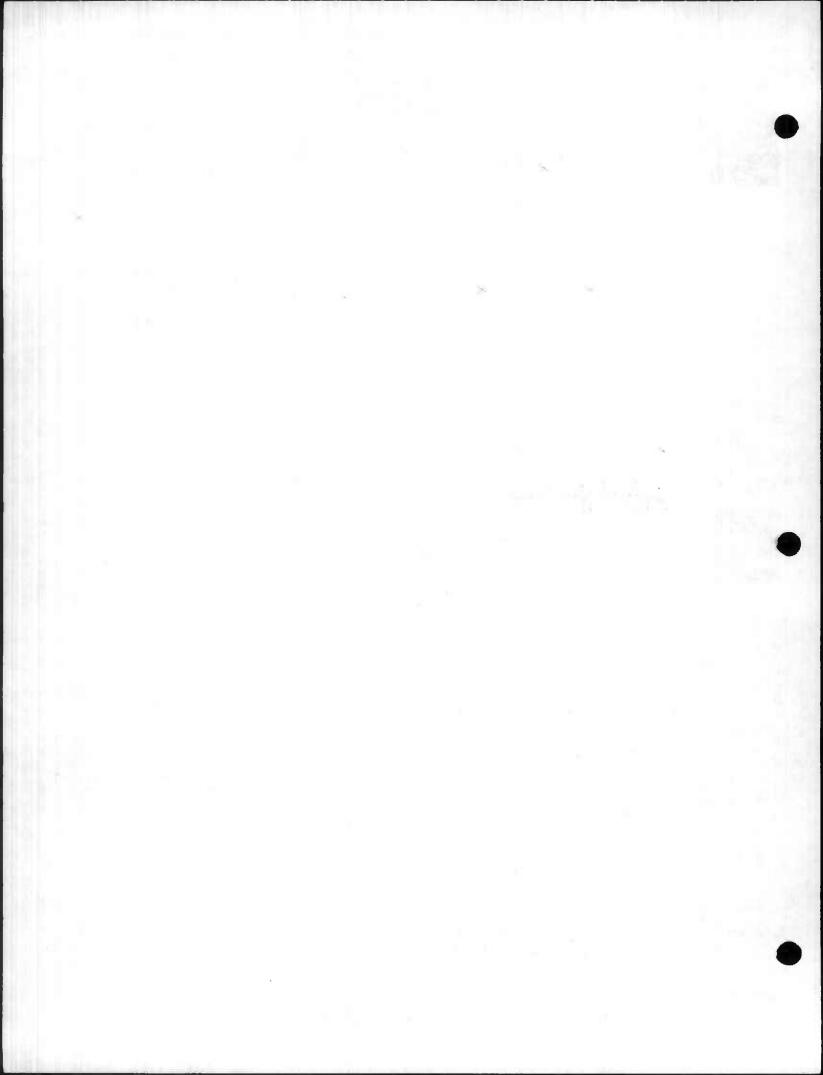
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

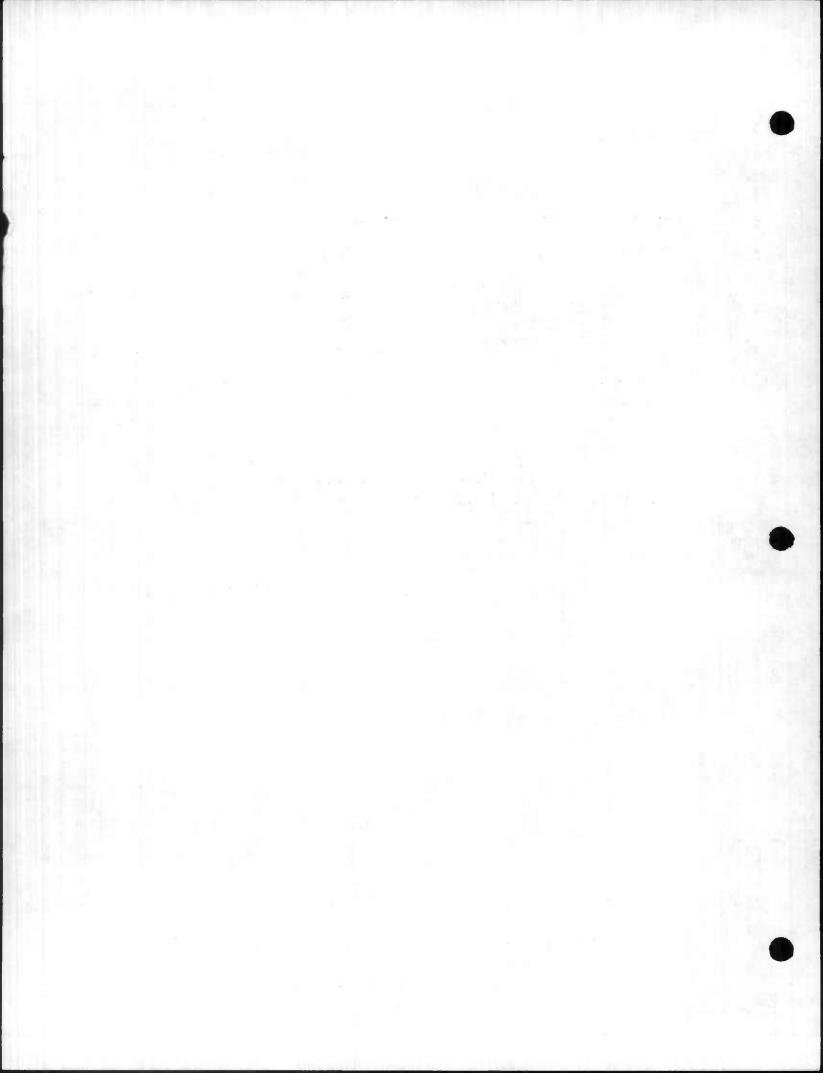
		1. Decedent's Nam	e (First, Middle, L	ast)		Cer	tificate of	Death	2. Date of De	Reg. No.	Ę.	3. Time of Death
Physic			Rob	ert Le	Roy	Tabler			Month	Dey ber 21, 1998	Year	5:00AM
/Med Exami		4e. Facility Name (	If not institution, gi		-			4b. City, Town, or		-	of Death	0.007.00
	Ш	6900 Strat	ford Drive					Sykesville			Carrol	
Funeral Director		5. Social Security N 220 - 16	- 0880	Sex 1 <b>X</b> M 2□ F	7. Age (In yrs	last birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs Hours Min.		th ay, Year)		lace (State or Foreign try) Maryland
inyland show		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	cation				10	0d. Inside City Limits
S M	Sch	Maryland		Carroll		Sy	kesville					1 MYes 2 No
with the	Dir	10e. Street and Nu					10f. Zip Code			10g. Citizen of V		try?
eath	erai	6900 Strat	ford Drive	12 Was Dace	edent Ever in t	IS 13 V	Ves Decedent of I	2 Hispenic Origin? (S	1784		U.S.A. e - America	an Indian
5-0020 72 hours efter death with the Maryland natural; or Nerns 23s or 28s-f show ore learning to not the death.	by Funeral Director		ied 2 Married 4 Divorced	Armed Fo	rces? 2 <b>X</b> No	If	Yes, specify Cub	Specify:	o Rican, etc.)		k, White,	etc.
	Completed by	(Specification)	15. Decedent's E cify only highest gr andary (0-12)	ducation ade completed)	-4or 5+)	(Give I	O NOT use retire	during most of wo	rking	16b. Kind of Bu		
		17. Father's Name	(First, Middle, Las	1)			Cheif Eng		me (First, Middle	, Maiden Surnam		aliu
arylan 2 should be and Mental is marked o	To Be		Rober		Tab	ler			Ella	, maiour ournain	Duva	
Maryland d2 should be file b and Mental Hy 7 is merked oth traumetic event	-	19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailin		and Number or Ri				Code)
CENL				Tabler/Wife	100	Di I Di		ratford Drive				
0 8 2 2 2			□Cremation 3 [		6.1		atory or other pla		Dete	20c. Location - Finksb		
Baltim pemit. Peg Department important: h any injury o		4 ☐ Donation 2t. Signeture of Fu	5 Other (Speci				Memoriai Gard	-	12/23/98			
Balt permit. Departrimenta any inje		1 Jeff	V. Zum	bru			6	DeffierNy Zur 3028 Sykesvil	norun Fune le Road Eld	eral Home & lersburg, Ma	ryland	21784
Centificate be executed from the continuation of the continuation of the centification of the	/Medical Examiner	Immediate Cause (disease or condition resulting in death)  Sequentially list conflant, leeding to incause. Enter Under Cause (Disease or that initiated events resulting in death) in the conflant initiated events resulting in death) in the conflant initiated events resulting in death) in the conflant initiated events resulting in death) in the conflant initiated events resulting in death) in the conflant initiated events resulting in death) in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting in the conflant initiated events resulting initiated events	nditions, nmediate rhying Injury	a	Due to (	or es e consequences	trtly jence of):	Distar			F	hollylors
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aw requir	Completed t	Pulm	many	Hyper	Husia	<b>n</b>				an autopsy ormed?	eva	re eutopsy findings illeble prior to apletion of cause leath?
- F # 6					,				10	Yes 2 No	1 🗆	Yes 2 No
Or Vital I Physicien: The this certificate rai director, per	Be	25. Was case reference examiner?		Hospital:			Out	hor	ath (Check only			
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nding ath. r: Afte	atior	1 ☑ Natural 2 ☐ Accident	5 Pending Investigation	(Mont	h, Day Year)	Injury	28c. Inju Wo M 1 □	rk?  Yes 2□No		, , , , , , , , , , , , , , , , , , , ,		
DIVISION OF tal or Attending Physics after death. at Director: After this led in by the funeral di	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	288. Place	of injury - At h	ome, farm, stre	et, factory, office		28f. Location ( City or To	Street and Number wn, State)	er or Rurei	Route Number,
Hospi 24 hou Funer stely fill	edical (	29a. Certifier (Check only one)	1☑ Certifying Pt 2☐ Medicai Exa	nysician: To the miner: On the ba and menr	sis of examina	owledge, deeth ation end/or Inv	occurred at the tilestigation, in my o	me, dete and piece opinion, deeth occu	, and due to the rred at the time,	cause(s) end me dete and place, s	nner as stand due to	ated. the cause(s)
To the within ? To the comple	Me	29b. Signeture and	title of certifier		7		29c. Licens	se number		29d. Date signed	(Month, L	Dey, Year)
- > - 0		•	10	001	MD			33184		Decemb	er d	1,1998
		30. Name and address Dr. Jonatha						Maryland 211	136			
Sta Regist		31. Dete filed (Mont	nFC 2. 2.	32. R	egisyar's Sign	ature	. Soon	11	_			



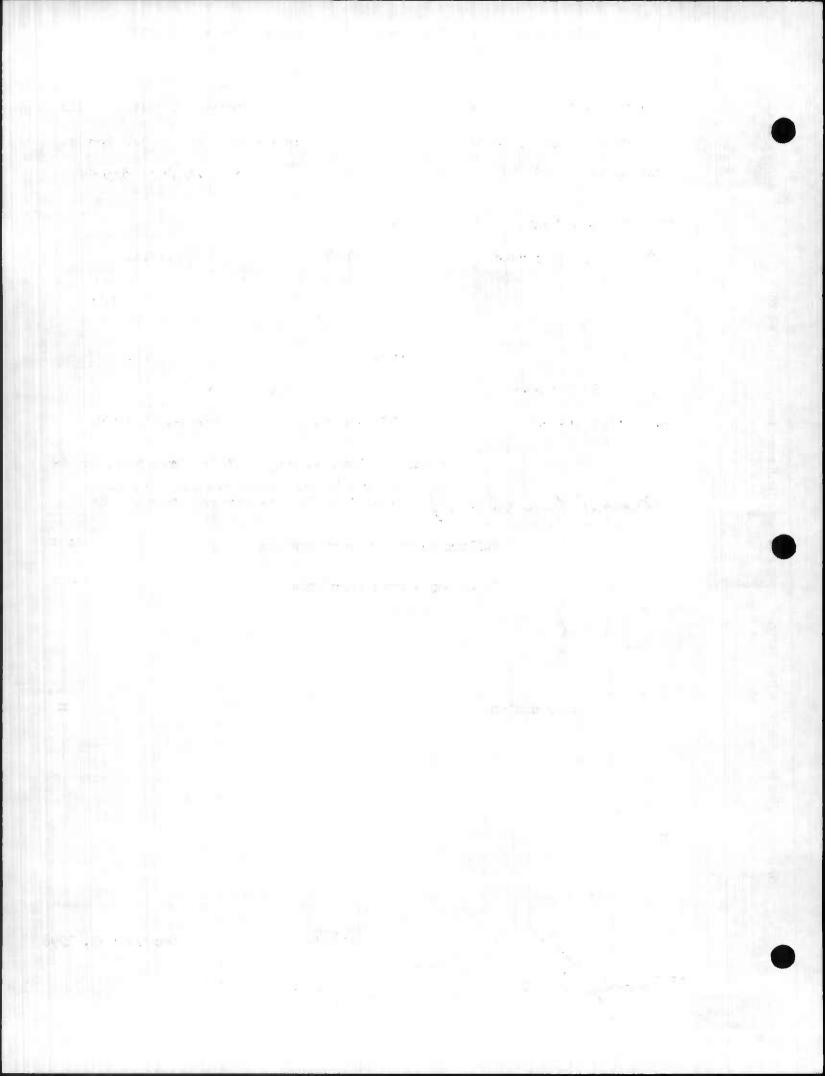
State of Maryland / Department of Health and Mental Hygiene

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		7210 Benedic	t Avenue					Bened			Char	les	
Funeral Director		5. Social Security Number 215–38–4868	6. Sex 1 □ M 202 F	7. Age (tn yrs. 90	last birthday) Yrs.	Months	r 1 Year Days	If Under 2	4 Hrs. 8 Min.	Dete of Birth (Month, Day, larch 2	1908	Cour	olace (State or Foreign try) ONS 1 N
pu k		Usual Residence of Decedent  10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation			-			1	Od. Inside City Limits
4 sho	10	Maryland Char	aloc		Bene	diat							1 ☐ Yes XIX No
158 Hou	70	10e. Street and Number	163		Delle	10f. Zij	Code			10	g. Citizen of \	What Cour	ntry?
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d within 72 hours after death with the Maryland distribution of the way of the work than 'natural', or herns 23s or 28s-f show the Madical Exercise must be inclined at	by Funeral Director	11. Meritat Stetus  1 Never Merried 2 Mer  3 Widowed 4 Divorced	ried Armed Fo	2 X No		Wes Dece if Yes, spe		tispanic Origi an, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Rac	k, White,	can Indian, etc. ite
72 hours	P	15. Deceder	t's Educetion		16a. Deced	dent's Usu	el Occup	oation	of words in a	10	6b. Kind of B	usiness/In	dustry
within 7	Completed	Elementary/Secondery (0-12)	st grede completed) College (1	-4or 5+)	life. I	DO NOT u	se retire	during most of d)	or working				
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should be nd Mental marked c	2	Wenzel Koller							Ko11				
0 0 2 5	1	19a. Informant's Name/Relations		la de a co	1					Route Number,			Code)
other tr	-	Anna L. Stonest  20a. Method of Disposition	reet-Daug						,	antown,	Oc. Location -		num Ptoto
8 5 5		1 Burial 2 Cremation			lace of Dispo								
rtmer rtami		4 Donation 5 Other (S		St				-	-	31-98 E	sryanto	own,	MU
permit. Pages 1 am Department of Heal Important: if Itam 2 any Injury or other once.		21. Signature of Funeral Service  David A. Go	No	95				eral H		Inc.	20604-	-0156	
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The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	o. Hel	perfe	ras e consequences as e consequences	N.	H	91 1	<b>V.T.</b>	25(-		1	
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or Attanding Physician: Tefer death. Director: After this certifical	9	25. Was case referred to medica						26. Place o	of Death (	Check only one	)	1	
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Attending Ph or death. ector: After th by the funeral		27. Manner of Death  1 Netural 5 Pendir 2 Accident investi		of Injury h, Dey Year)	28b. Tima of Injury	м	28c. Inju Wo 1 □	ryat rk?  Yes 2 N		d. Describe how	v injury occur	red	
To the Hospital or Attanding Physician: The law within 24 hours effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 8 Could 4 Homicide determ	ined 288. Place	of Injury - At ho ng, etc. (Specify	ome, ferm, stri	eet, fector	y, office		28	Location (Stre City or Town,		er or Rure	at Route Number,
n 24 houpi n 24 hou ne Funer sletely fill	edical		g Physician: To the Examiner: On the ba and menn	sis of examine									
Withir To th		29b. Signeture and title of certifie	0 - 2 /					se number		29	d. Date signe		
		1 los	Math			-	DI	258	7		12-3	29-0	18
	-	30. Name and address of person		e of death (Item	23a) (Type, I	Print)							
		G. Shankar Rat	h, 7C Pos	t Offic	e Road	, Wa	Idor	f, MD	20602				
Stat	e	31. Data filed (Month, Day, Year)	32. Re	egistrar's Signe			1						
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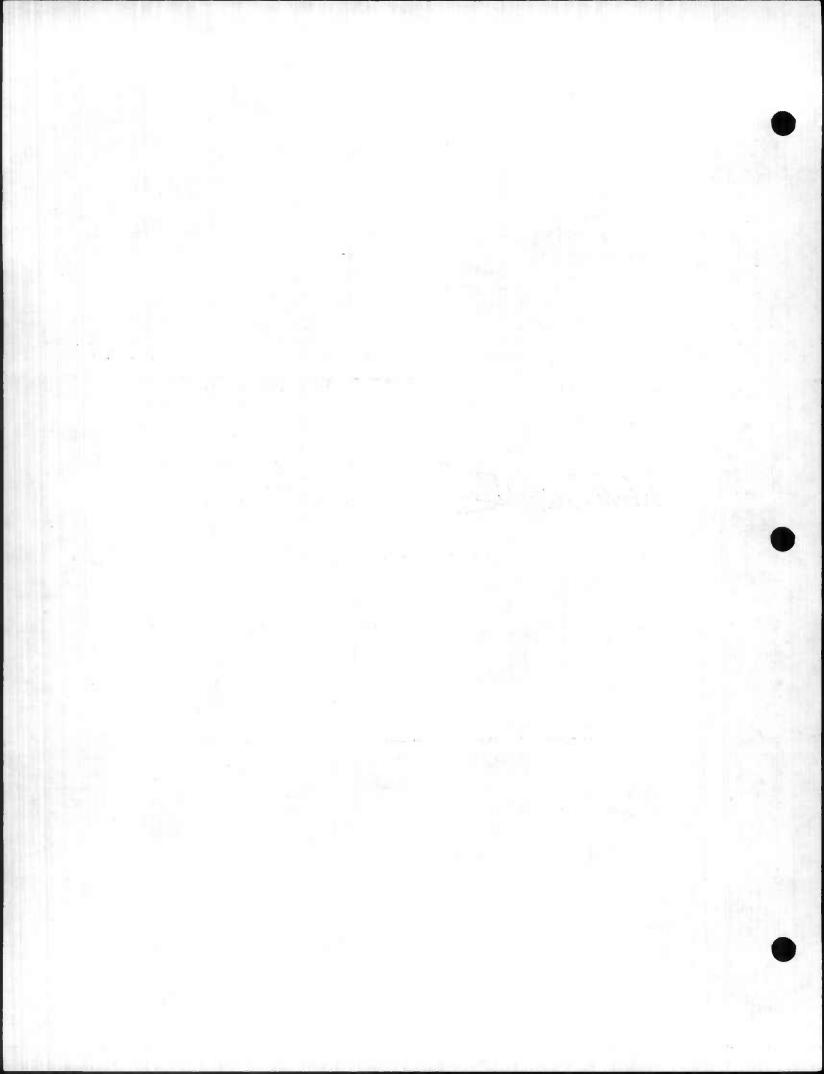
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/Medi		JONN 4a Facility Name (#		e Thomaso					4b. City, Town, o	_		4c. County	of Death	,1.,1	: 50 am
Examir	ner			sing Cent											
		5. Social Security Nu			er Age (In yrs.	la et hirti	hday) If U	ndar 1 Yaar	Leonard		Birth		. Ma	,	ate or Foreign
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deep deep	Funeral	11. Marital Status		12. Was Deceder Armed Forcas		,S.	13. Was D	ecedant of h	Hispanic Origin? an, Mexican, Pue	(Specify Yes or	No-		e - Americ k, Whita,		n,
21215-0020 d within 72 hours efter deeth with the Maryland giene. r than "natural", or flems 23a or 28a-f ehow that Medical Examiner must be notified at	by	1 🔯 Nevar Marrie		1 Yas 2 N If Yes, Give Yaar or Dates	No			s 2∏No	Specify:	orto ritograf otto.		Specify			
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0 80 7		20a. Method of Dispo 1    Burial 2   □		Removal trom Stat	20b. I	cemeter)	y, crematory	(Name of or other pla	ce)	Date	20	Oc. Location -	City or To	wn, Stai	a .
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Baltimore, permit. Pages 1 a Department of Hes Important: If item any Injury or othe page.		21. Signatur of Fun	neral Sarvice Licar	nsaa	,		Matt	e and Addre	ess of Facility y-Gardin	er Fune	ral	Home.	P.A		
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/Medical Examiner		Immediata Cause (F disease or condition	inal	ral	Lure	OT 1	major	organ	systems	3				0110	
Examiner		resulting in death)		a.			onsequence						1	6 m	0.5
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ding ding	tion	Natural Natural	5 Pending investigation	(Month, E	ay Year)		njury M	28c. Inju	rk?  Yes 2□No						
Division  or Attending after deeth. Director: After d in by the fune	fica	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not b		niury - At h	ome, far	rm, street, fa			28f. Location	on (Stre	eet and Numb	er or Rura	l Route	Number,
Div.	Certification:	4  Homicide	determined	building,	etc. (Speci	fy)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or	Town,	State)			
Division of the Hospital or Attending Fwithin 24 hours after deeth. To the Funeral Director: After completely filled in by the funeral	S S	29a. Certifier	1⊠ Cartifying Ph	yalclan: To the bes	at ot my kno	wledge.	death occu	rred at the ti	me, dete and pla	ce, and due to	the cau	use(s) and me	nner as s	tated.	
24 h 24 h Fur	edical			niner: On the basis and manner	of examine										ise(s)
of the comp	Me	29b. Signature and to	itie of certifier	1				29c. Licens	se number		290	d. Date signe	d (Month,	Day, Ye	ar)
			-5 V					DOST.	27			Decemb	er 2	1, ]	.998
100		30. Name and addre	of personwho	completed gause of	death (Iter	n 23a) /	Type Print)								
0		Eugene	+-4	BY C		=50) (		Chapti	ico, Mar	vland ?	2062	11			
Sta	ite	31 Date filed (Month	hay Voort	32. Regis	strar's Signa	ature		J. a per		, - 4.1.4		-			
Registi		DEC	2 1 1998	Edne.	u	6		, )	4						
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State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg. No.	41223
Characteries	1. Decedent's Name (First, Middla, L	ast)				2. Data of De		3. Time of Death
Physician /Medical	Marie Thompso	on				Dec		998 /2:50 PI
Examiner	4a Facility Name (If not institution, g	iva street and number)			4b. City, Town, or			
	Moran Manor 1	Nursing Hom	e		Western	port	Alle	gany
Funeral Director		Sex 1 M 2 F 96	yrs. last birthday) Yrs.	1 11 11 1 1 1 1 1	If Under 24 Hrs.	8. Data of Bir (Month, Da	th ly, Year) 2,1902	Birthplace (Stata or Foreign Country)     Maryland
2	Usuel Residence of Decedent		01 T					
aryla ahow	MD Allega		City, Town or Li					10d. Inside City Limit
cto cto	Allego	illy	Wester	uborc				Y Yes 2 N
iter death with the Marylar retains 23a or 28a-f show the mark be notified at Funeral Director	10e. Street and Number 25701 Shady 1	Lane		10f. Zip Coda 2156	2	1	10g. Citizen of WUSA	hat Country?
her death	11. Meritel Stetus	12. Was Decedent Ever i	in U,S. 13.		Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No		- American Indian,
by		Armed Forcas? 1 ☐ Yas 2 ☐XNo If Yas, Giva Year or Detes:		1 Yas 2 No		o riican, etc.)		white, etc.
ed within 72 hours ygiene. ser than "natural", rt, the transcell Ex Completed by	15. Decedent's E	Education	16a. Dece	dent's Usuel Occu	pation	kina	16b. Kind of Bus	siness/Industry
within and the state of the sta	Elementary/Secondery (0-12)	Collega (1-4or 5+)	life.	DO NOT use retire	during most of world)	nary .		
Hygiene. ther than om, tre the	12		Hor	nemaker			Own 1	Home
ETES a	17. Father's Nama (First, Middla, Las	t)			18. Mothar's Nan	na (First, Middle	, Maiden Sumame	)
Mental Mental arked o	Ed Gillespie	3			Anna I	Luciene	9	
and and and and	19a. Informant's Name/Relationship				t and Number or Ru			
Health of the state of the stat	oseph Thompson-	son	2460	02 Dobe:	rman Di	SW We	esternpe	ort MD 2156
of He of He r oth	20a. Method of Disposition		b. Place of Dispo	osition (Name of matory or other pla	ice)	Date	20c. Location - 0	City or Town, Stata
Y o H	1 ☐ Burial X☐ Cremation 3 i	☐Removal from State ifv)			emetery	2/98	Cumber	land
1 2 2 2 3	21. Signature of Funeral Service Lice	/ ^						24114
Depa Impo any i	1/2/ /// //	111/11/11	- 8		ass of Facility CK Fune:		ne	
	1 Cont Du	WOWL			ont, WV			
	23a. Part1. Entar the disease, or cor shock, or heart failure. List only	y one cause on each line.	Do not en	tar the mode or dy	ng, such es cardiac	or respiratory a	rrest,	Approximate Interval Between
Physician								Onset and Death
/Medical Examiner	tmmediata Causa (Final disaasa or condition	Gen	era lize	of Sy	875			1 weeks
	resulting In death)	Due !	to (or as a conse	quance of):	11/1			
e e								
tificate be executed to physician and as the burial-transit redical Examiner	Sequentially list conditions.	Dua t	o (or as a conse	quance of):				Ť
tificate be executing physician and as the burial-tran	Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated evants							
cal bu	Cause (Disaasa or Injury that initiated evants	c. Due t	o (or as a consec	ruence of):				
as the se	resulting In death) Last							
nigin Ngin		d						
death of attended for u	Part II. Other elgoiffeent conditions	contribution to don't but not	reculting to the	ndomino couco ci	von in Part I	225 Did	tohana was oon	billiude to the server of dest
the death certification of the attending letterhed for use a Physician/M	Part II. Other significant conditions		เสรยเสาฐ เก เทช บ	nuenying ceusa gi	ven in ran I.			tribute to the cause of deat
y P	Coron	rung Drifus	2 Disc	ese		10	Yes 2□ No	3 Probably Tolking
2 20 2		1	(			24a Was	an autopsy	24b. Were autopsy finding:
The law require pate has been single 2 should Completed						perfe	ormed?	available prior to completion of cause
has the person mpi								of death?
Page Corr						10	Yes 25 To	1 ☐ Yes 2 ☐ No
Physician: this certific and director. TO Be (	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only	one)	
hysic of I dire	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Ot	her: 412 Nursing H	lome 5 Resi	dence 6 Othe	r (Specify)
g Pt	27. Manner of Death	28a. Data of Injury (Month, Day Year	r) 28b. Time o	28c. tnju Wo	ry at	28d. Describe	how injury occurre	ed .
atic atic	Natural 5 Pending invastigation		.,,.,,		Yas 2 No			
or Attending after death. Director: Afte I in by the fune ertification	3 Suicide 6 Could not l 4 Homicide detarmined			reet, factory, office		281. Location ( City or To	Street and Numbe wn, Stata)	or or Rural Routa Number,
To the Hospital or Attending Physician: The law within 24 burus after doasth, within 24 burus after doasth, to the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying P. (Check only one) Medical Exa	hysician: To the best of my miner: On the basis of axem and manner stated.	knowledge, deat ninetion and/or In	n occurred at the ti	ma, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
Med Med	29b. Signatura end title of certifiar	and mannar stated.		29c. Licen	sa numbar	1	29d Data singed	(Month, Day, Year)
5 × 5 × 5	200. Signatura eno litre di certinar							
5	1				21244			R 26 1998
	30. Nama and address of person who	complated cause of deeth (	ttem 23a) (Type,	Print)	vostbur	4 4	A > -	
Ms	Jesus Tan, M.	D. rvostbi	ura Pl	aza t	vostbur	g MI	0 712	32
State	31. Data filed (Month, Day, Year)	32. Registrar's Si		parks		)		
Registrar	DEC 2 9 1998	1	19	SALKO				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Eugene Earl Tolson /Medical 4a Facility Nama (If not Institution, giva street and number) Town, or Jocation of Death 4c. County of Death Examiner If Under Months nepa 0 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year . Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country)
Mary Land 5. Social Security Number **Funeral** Days 577 44 4461 NOM 20 F Sept 1, 1931 Director Usual Residence of Decedent the Maryland 10a. Stata 10b. Counh 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yas 2 ☐ No Director Clinton P.G 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9805 Brandywine Road United States 20735 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1♥D\res 2 □ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene. other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mentel Hyglens Important: if item 27 is marked other the eny injury or other treumatic event, that page. Self Employed Seafood Restraunt 10 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) 8 Nellie Helen Bowish Alfred Raymond Tolson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 9805 Brandywine Road, Clinton, Maryland 20735 (WIFE) Nancy Tolson 20b. Place of Disposition (Name of cematery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory Dec 19, 1998 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licent Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examine Due to (or as a consequence of Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰ Unknown Didles oronou þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours etter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-15-78 D-0053713 Janon Inomas 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 13 Alexander VA Hanssn Momas

DHMH 16 Rev 6/95

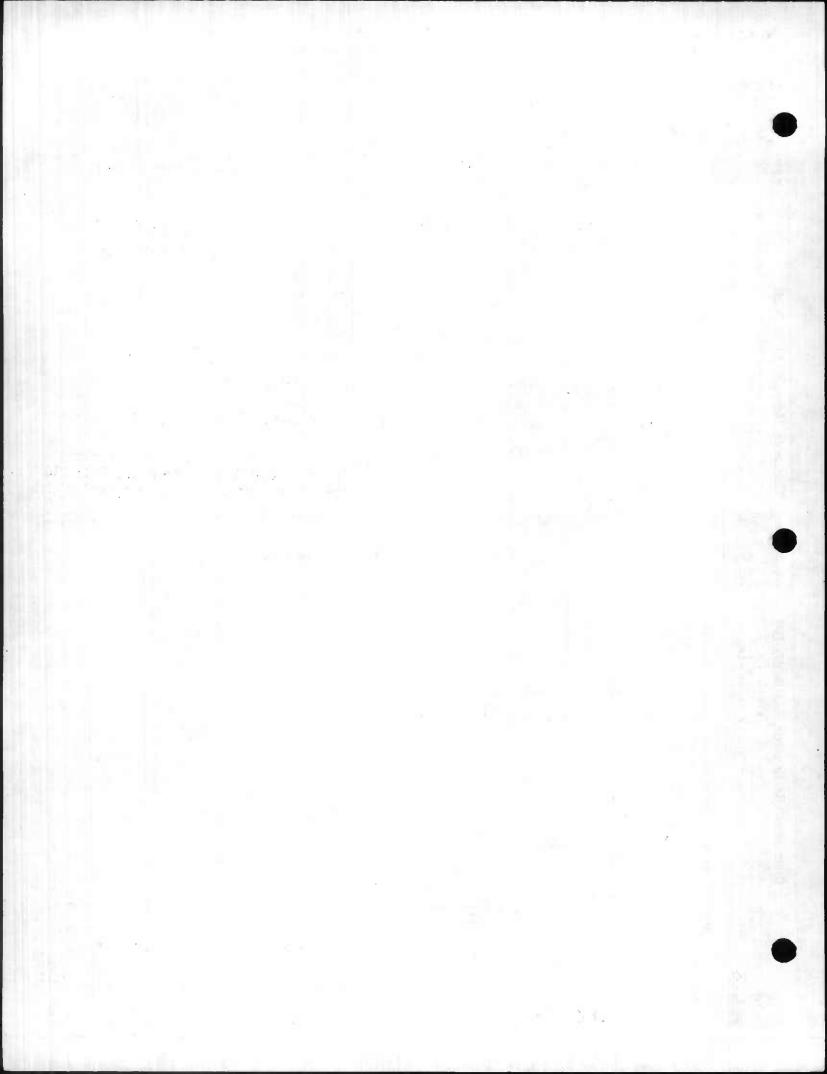
Registrar

31. Date filed (Month, Day, Year)

DEC 17

1998

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vest Physician 11:45 Robert Bernard Taylor 998 Dec /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner St. Agnes Healthcare Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 19, 1919 Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M 20F 579-05-8118 79 Director Wash., Usual Residence of Decedent 10s. State 10b. County 10c City Town or Location 10d. Inside City Limits man be notified at 1 □XYes 2 □ No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1440 Rock Creek Ford Rd.; #T13 20011 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. African 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working title. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12th Businessman Self-Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any injury or other traumatic event, place. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumame) Be Robert Taylor Georgia Johnson 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Taylor - Wife 1440 Rock Creek Ford R., #T13; Wash., D.C. 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/98 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. Suitland, MD 21. Signature of Euneral Service Licenses 22. Name end Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Part V inter the disease, or complications that caused in coars. show, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final Cancel CAL リム disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? OBERT 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation Division Attending 1 ☐ Yes 2 ☐ No deeth. 2 Accident after deetl Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurat Route Number, City or Town, State) 4 Homicide 6 To the Hospital within 24 hours To the Funeral completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) 29b. Signeture and title et certifier 29c. License number 29d. Data signed (Month, Day, Year) Menkonle, MD 046704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES HOSPITAL, BLT, MD KAN KONDE MUTOMBO 31. Date filed (Month, Dey, Year) DEC 2 4 1998 32/Registrar's Signeture State Registrar

DHMH 16 Rav 6/95

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State of Maryland / Department of Health and Mental Hygiene \( \)

				C	Certificate of	Death	Re	g. No.	416	-6.0
Physicia	ın	Decedent's Nama (First, Midd					2. Dete of Death Month	Day	Yaar 3.	Time of Death
/Medic		Thelma	Smith		Tanner		December	19, 1	998 1:	30 P.M.
Examine	er	4a. Facility Nama (If not Institution		r)		4b. City, Town, or L		4c. County		
		6626 St. Barn	abas Road			Oxon Hil			e Georg	ges
Funeral Director		5. Social Security Number 578-32-7811	6. Sex 7. /	Age (In yrs. last birtho	Months Devs		8. Dete of Birth (Month, Day, May 26,	Year) 1917	9. Birthplace Country) Maryla	(State or Foreign and
2		Usuai Rasidance of Decedent		1						
show at an		10a. State 10b. Count		10c. City, Town o						side City Limits
notified a	Funeral Director	Maryland Prin	nce Georges	Oxon	Hill				12	QYes 2□No
ms 23a or 28a-f show c must be notified at	Sire	10e, Street end Number			10f. Zip Coda		10	g. Citizen of W	/hat Country?	
238	a	6626 St. Barr	nabas Road		20	745	1	United	States	
Home Inches	ner	11. Merilei Stalus	12. Was Deceder	t Ever in U,S.	13. Was Decedent of I	Hispenic Origin? (Sp	ecify Yes or No-		- American in	dian,
- 3	ρ	1 Nevar Married 2 Me	If Yes Give	] No	1 ☐ Yas 2 No		Hican, etc.)		k, White, etc. Black	
S S	To Be Completed	15. Deceda	nt's Education	18a. De	ecedant's Usuai Occu	pation	1	6b. Kind of Bu	siness/industry	/
2 0	흥	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4o	(G	live kind of work done e. DO NOT use retire	i during most of worked)	ing		vernmei	
2 4 4	E	12th grade	College (1-40	Pr	inter's As	sistant		Printi	ng Off:	ice
d other event, n	0	17. Father's Nama (First, Middle	, Last)			18. Mothar's Nam	a (First, Middle, M	aiden Sumam	e)	
D D D	m	George	S	mith		Blanc	he	V	Villiam:	S
marked matic e	F	19a, Informant's Name/Relation	shin /Time Print® or a	- of 10b M	lailing Addrass (Street	t and Number or Pu	rei Pouto Alumbar	City or Town	State 7la Code	1 207//
tem 27 is marke other trsumatic	- 1	TIA - A Man	amp (1)pa, 11mi)POWe	Attor	ney)					
ther the	+	Winston A. Maco	JII (Administr	ator & 1	2803 Durne	ss Circle	Port Wa		Oil, Mary. City or Town, S	
or H or		Matrice of Disposition	3 □Removal from Stat	e cemetery,	isposition (Name of crematory or other pla	Dec. 28,	1998			aryland
Lant:		4 Donation 5 Other (S	Specify)	Marylan	d Veterans	Cemetery	/Chelten	ham		
Department of Her Important: If item any injury or othe pace.		21. Signature of Funerel Service	Licensee	. 11	22. Nema and Addre	ass of Facility Ro	bert G. 1	Mason F	uneral	Home, In
0 5 3 8	Î	Mohen	G. 15	The last	1661 Good	Hope Roa	d,S.E.;W	ashingt	on,D.C	. 20020
		23a. Part1. Entar tha disease, o shock, or heart failura. Lis	r complications that caus	ed tha death. Do not				_	Appi	roximata
ysician		SHOCK, OF Heart failura. LIS	t only ona causa on aach	ina.						vai Between et and Death
Medical		immediata Cause (Finai	1) no	ner less	· Inil	1150				
aminer		disaese or condition resulting in death)	a. (5)	urusoru	rull	WE				
	6		011	Due to (or as a coc	sequence of):	901-1	1/4-0-31	- Drive	n. 1.	1001/2
_ SS .	Examiner		6. / / W	rustura	Carn	uroful	IKNOWI	חוישה	maji	nonths
al-tra	X	Sequentielly list conditions, if any, laading to immadiata		Due to (or as a con	sequence of):	,		•		
		Sequentielly list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury	С						4	
the :	Medical	that initiated events resulting in daeth) Last		Due to (or as e con	sequence of):					
	§									
tend or us	Physician/		<b>-</b> 0.						i	
e de	S	Pert II. Other significant conditi	ons contributing to death	but not resulting in th	a undarlying causa gl	van in Part I.	23b. Did tol	acco use con	tribute to the	cause of death?
tach i	١٩	ih in a Atrice	$\Omega \Lambda$				1 🗆 Ye	0 2□ NO	3 Probably	4 Unknown
pe de	ò	11 yrer wish	73							
been signed by the attendir should be detached for use	8	Propochia	1 lens	Zaliwa.			24a. Was an	autopsy		utopsy findings
	<u>e</u>	Convestor	C FRUIT	failure			perform	ed?	complet of death	s prior to ion of cause
certificate hes irector, page 2	Completed	1/2000	17.100							
r. pa		Venous	Irsutticle	ncu			1 🗆 Ya	s XXNo	1 🗆 Yes	2010
ecto ecto	e e	25. Was case referred to medical examiner?			l au		h (Check only one	)		
this din	0	1 ☐ Yes 2√XNo	Hospital: 1 Inpa	The second second	itient 3 DOA	her: 4 Nursing Ho	me 5 Resider	nce 6 Othe	er (Specify)	
ner t		27. Manor of Death 1 Whatural 5 ☐ Pendi	28a. Data of In (Month, D	jury 28b. Tim lay Year) Inju	a of 28c. Inju	iry at	28d. Describe hor	w injury occurr	ed	
within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	ä		igation			Yes 2□No				
by the	<u>≅</u>	3 Suicida 6 Couid 4 Homicida datam	ningd 288. Place of I	njury - At home, ferm,	streat, factory, office		28f. Location (Str. City or Town,	eet and Numbe	er or Rural Rou	rte Number,
<b>9</b> 6	Certification:	4   Hormonda	ounding, a	itc. (Specify)		LI LI	City of Town,	State)		
# H		29a. Certifiar 1 Certifyin	ng Physician: To the bes	t of my knowledga, da	aath occurred et tha ti	ma, data and piace.	and dua to tha ca	usa(s) and ma	nner as stated.	
Fur etely	edicai	(Check only 2 Medical one)	Examiner: On the basis and mennars	of axamination and/o	r invastigetion, in my o	opinion, death occur	red at the tima, da	ta and place, a	ind dua to the d	cause(s)
To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ž -	29b. Signatura and titla of certific			29c. Licens	sa number	20	d. Date sinner	(Month, Day,	Year)
8 4:			) 11	-		11/5/11	C. 11		41	
			JUIN	MP		11 000	74 D	ecember	H,	1998
01		30. Name and address of person	who complete use of	death (Item 23a) (Tv	ne. Print)					
-			7							
/		Emerson L. Con	7			oad, Suit	e 101;Su	itland,	Maryla	nd 20746
State			cone1, M.D.;			oad, Suit	e 101;Su	itland,	Maryla	nd 20746

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Death 3. Time of Deeth Month

**Physician** /Medical Examiner

**Funeral** 

Director

the Maryland s 23a or 28a-f show death hould be movid Mental Hygiene.
merked other than "natural", or items?

filed within 72 hours efter 7 is marked other traumatic event, Peges 1 and 2 should be nent of Health and Mental nt of Health e If Item 27 is or other train permit. Pege Department of Important: If any injury or once.

21215-0020

Baltimore, Maryland

Physician /Medical Examiner

The law requires that the death certificate be executed bunal-tren P.O. Box 68760. physician the for use es signed by of Vital Records, should be peed After this certificate Attending Physician: director, Division

spital or Attending Physical or after death.

neral Director: After this of filled in by the funeral di To the Hospital or within 24 hours all To the Funeral D completely filled I Medicai

Wavelon D. Talley December 16 1998 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Washington Adventist Hospital Montgomery Takoma Park if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) Days 1□XM 2□ F Yrs 578-38-6010 Nov. 9, 1932 66 Wash., D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Director Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7900 Riggs Road 20783 Funeral United States 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: African 1 ☐ Yes 2 ☐ No Completed by 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Warehouse Manager 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Richard C. Talley Blanche Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Helen D. Talley - Wife 7900 Riggs Road, Hyattsville, MD 20783 20b. Pieca of Disposition (Neme of cemetery, cremetery or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/98 Triangle, VA Quantico National Cem. 21. Signature of Funeral Service License 22. Name and Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 elle de Pert 2. Anter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, about, or heart fallure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting In death) Cardiac Arrest Due to (or as a consequence of): Arythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Probable Prostate Cancer P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 Yes 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 🖺 ER/Outpatient 3 ☐ DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DNeturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29b. Signature end title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin-

29c. License number DO 3835

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

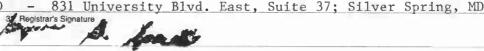
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Dey, Year) December 21, 1998

1 ☐ Yes 2 ☐ No

David Cromwell, MD State Registrar

29e. Certifier



**DHMH 16 Rev 6/95** 

2:27AM

10d. inside City Limits

One Hour

1X Yes 2 No

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DARRYL F. TELFAIR December 22,1998 2:20 AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Gladys Spellman Nursing Facility Cheverly Prince George's If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7/14/64 **Funeral** 12 M 2 F Months Days 34 577-94-5141 Director Wash., D.C. Usual Residence of Decedent the Marylend 10a State 10b County 10c. City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mexical Examiner naist be notified at D.C. N/A Washington XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4612 Quarles St., N.E. 20019 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filt ment of Heelth and Mental Hyant; if Itam 27 is marked oth jury or other traumatic event Francis Telfair Joan Bond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Telfair/Mother Same as # 10 above Saltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If any Injury or once. 12/29/98 Harmony Mem. Park Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. garry W. 4925 Burroughs Ave., N.E., Wash., D.C. 20019 (Tratt 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel Selvin IT alow disease or condition resulting In death) Examiner Due to (or as e consequenca of): Examiner physician and the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be Physician/Medical Due to (or as a consequence of): attending p 23b. Did tobacco use contributs to the cause of death? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Vegetative State 1 Yss 2 No 3 Probably 4 Unknown 2 CHIONLY signed b Records, à 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed peen has 1 Yes 2 No 1 TYes 2 No certificata Division of Vital director, 25. Was case referred to medical Be 26. Placa of Death (Check only one) exeminer? Other: 4 Universing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 this funeral 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 1 ENatural 5 Pending Investigation Attending or Attending after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Pertifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 025077 ms. would. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7407 Executive place Jentrack, mo 20701 mo strussaldof . El noc 31. Date filed (Month, Day, Year) 3. Registrar's Signature State DEC 2 4 1998 Registrar

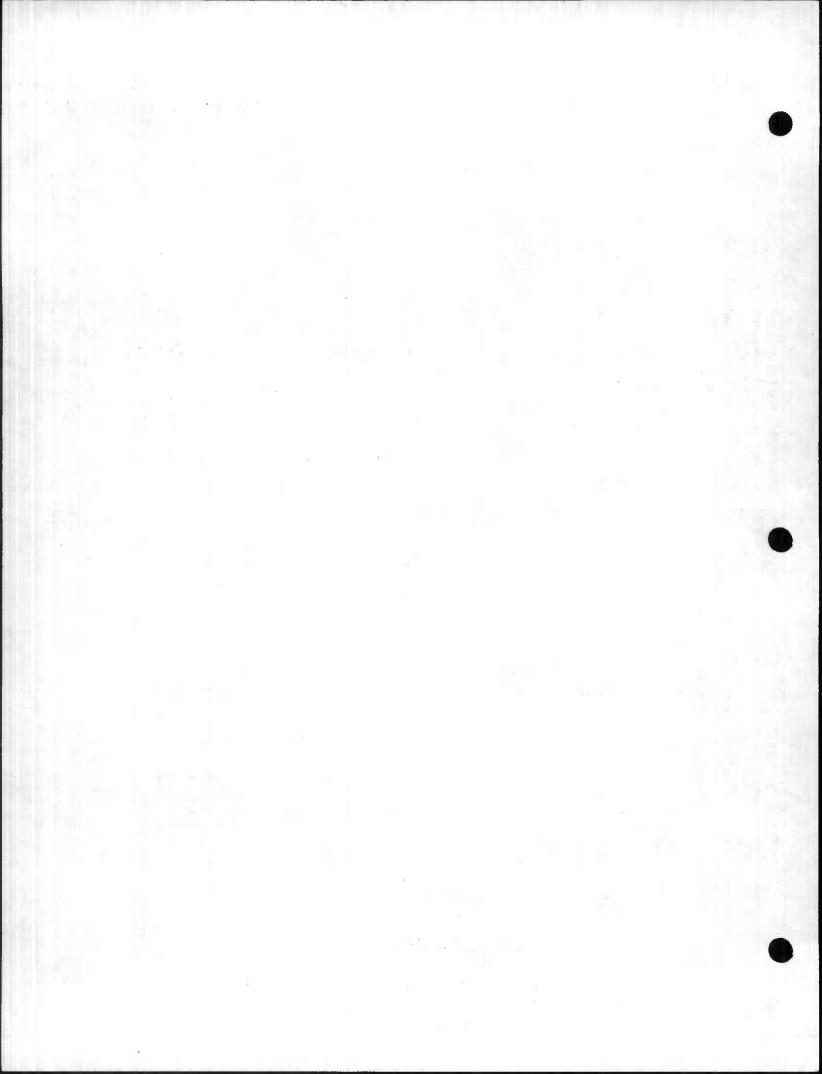
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDDIE JOE VANOVER, SR. 28, 9:17 PM December 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Civista Medical Center La Plata Charles 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or run) Jan. 9, 1933 West Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 235-52-7064 1 M 2□ F 65 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or hema 23a or 28a-f show to Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 Rivermont Drive 20602 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after in Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or then any injury or other treumatic avent, the Medical Emerican page. 1 ☐ Yes 2 💢 No If Yea, Give Year or Detes: 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orville 2 Vanover Dixie Hoosier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 Rivermont Drive, Waldorf, Maryland Joan L. Vanover/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens 12/31/1998 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Facili Huntt Funeral Home, Inc. JOHN P. KNISLEY M01164 P. O. Box 156, Waldorf, MD 20604 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Atternoscherotic sician and burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician is the burial P.O. Box 68760, Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yaa 2 No 3 Probably 4 □ Unknown Be Completed by Records. 24b. Were autopsy findings available prior to 24a. Was an autopsy parformed? completion of cause of death? page 2 t□ Yes 2 XNo 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 3☐ ER/Outpatient 3☐ DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 001923 De 29, 1998 12 Freldon 30. Name and address of person who completed cause of death (ttern 23a) (Type, Print) Thomas L. Fieldson, 2068 Crain Highway, Waldorf, MD 20601 31. Date filed (Month, Day, Year) DEC 3 1 32. Registrar's Signature

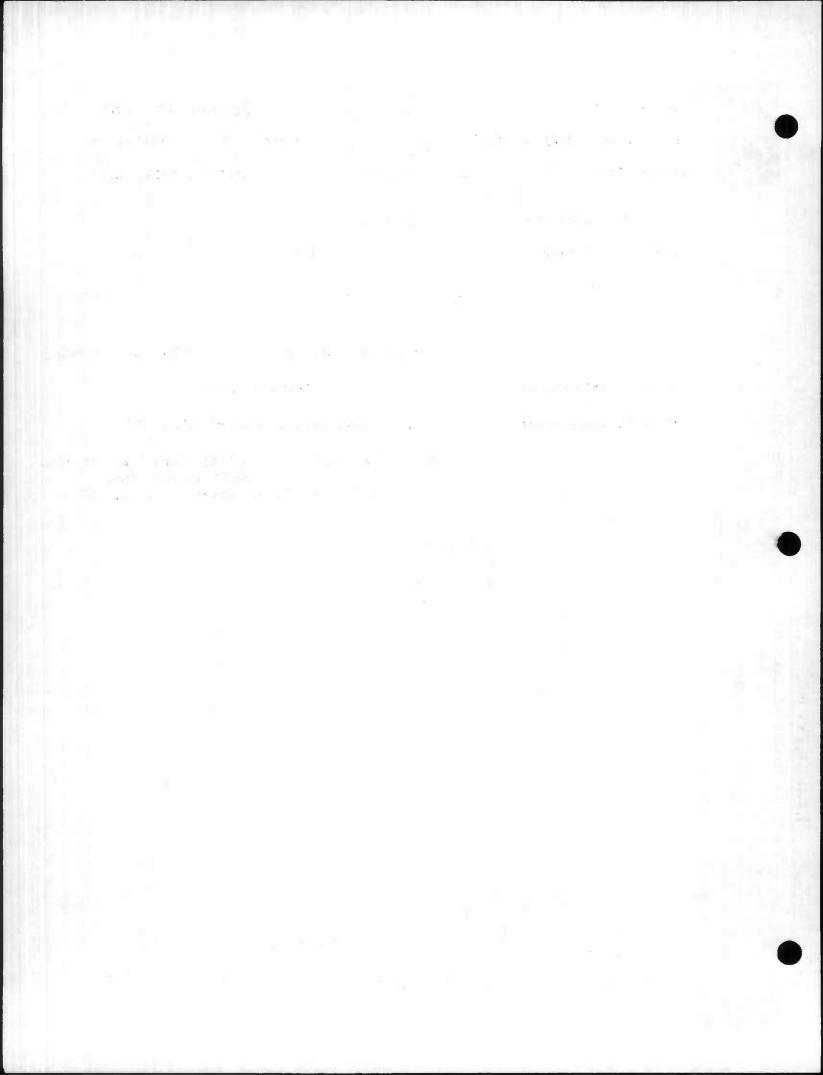
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State Registrar



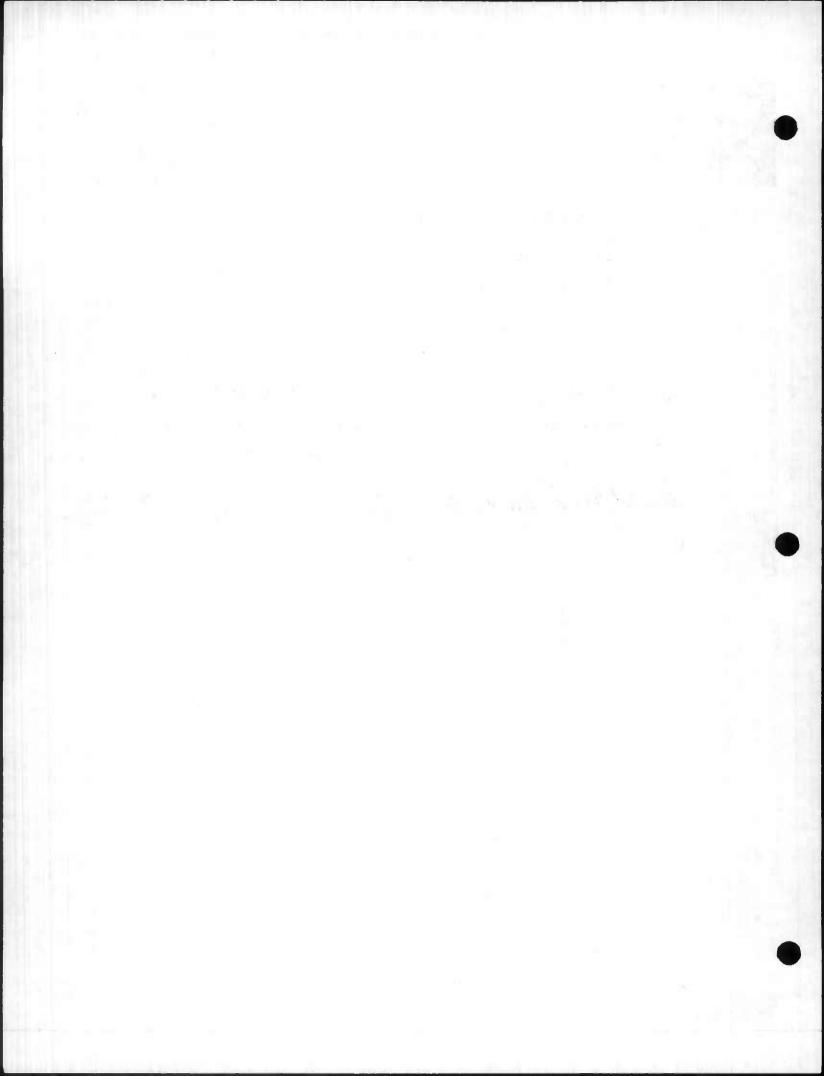
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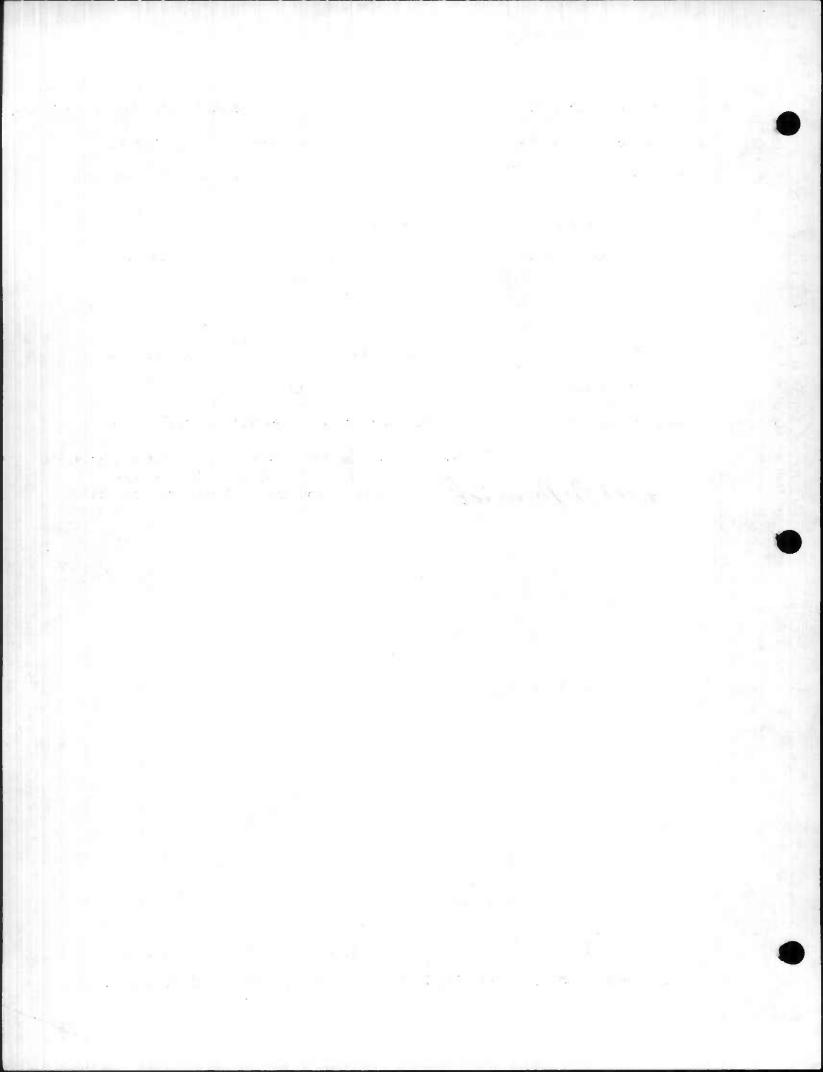
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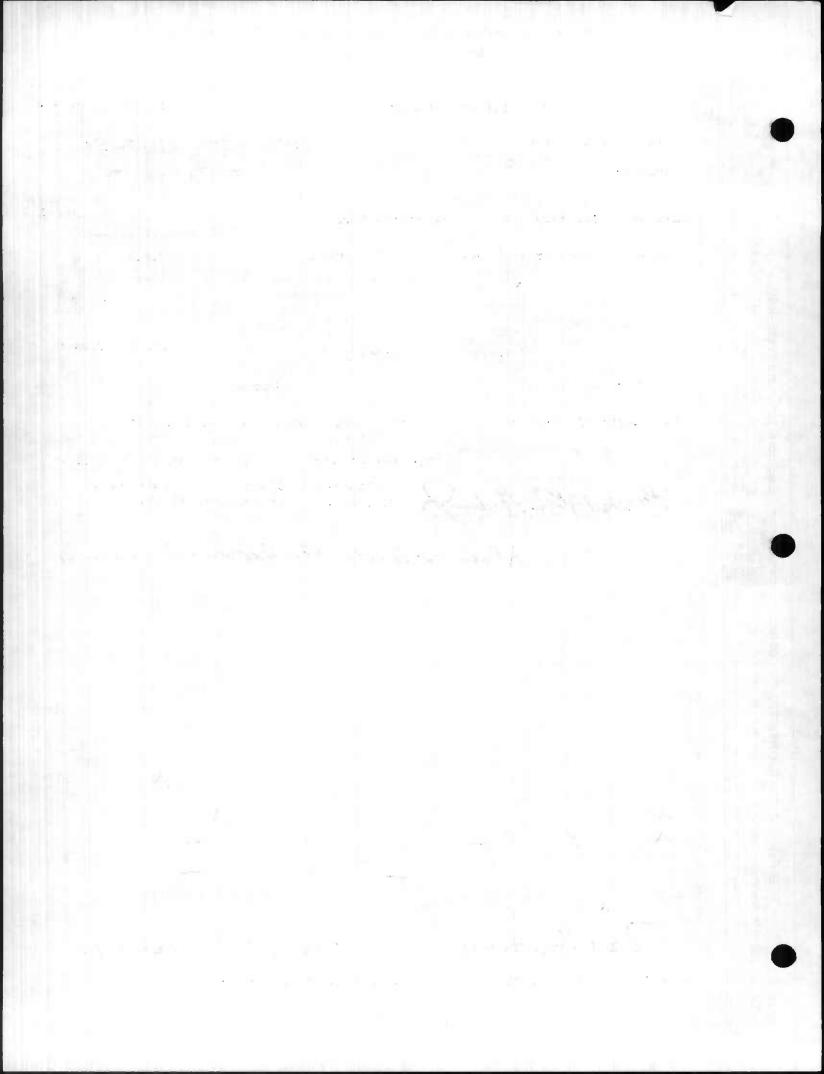
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				Certific	ate of L	Death	Reg	. No.	71600
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	п	46354	Columb	ous D	rive #	£1103				Lexing	ton Park	St.	Mary	1 s	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath **Physician** Month Year Walls December 19, 1998 3:03pm. Etta /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's Co. 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2⊠F 99 Yrs. Director 220-48-6347 May 7, 1899 Clinton MD 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 Yas 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 11000 Brandywine Road 20735 U.S.A. Itams 23a Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Raca - Amarican Indian, Biack, Whita, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) traumatic avant, the Medical Examiner 1 Nevar Married 2 Married Black ŏ 1 ☐ Yas 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced 15. Decadant's Education (Specify only highast grada complatad) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry la! Hygiene. Elemantery/Secondary (0-12) Collega (1-4or 5+) Home 7th Homemaker 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) . Pages 1 and 2 should be file ment of Health and Mental H-ant: If item 27 is marked oth jury or other traumetic avan Be Josiah Proctor Ida Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 11000 Brandywine Road Clinton, Maryland 20735 Andrew Walls (Son) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 23, Dec. 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 1998 Resurrection Cemetery Clinton, Maryland 21. Signature of Funaral Sarvice Licansea 22. Nama and Addrass of Facility Lee Funeral Home, Inc. the 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Between Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in daath) Examiner use as the burial-tran Saquentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseese or injury that initiated events rasulting in daath) Last Physician/Medicai Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed deligheation 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No Be 25. Was case refarred to medical 26. Piace of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) P 1 Yes 2 No DSInpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Death Deta of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 \ Homicida

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria sate has been signed by page 2 should be detach After this certificate Attending Physician: al or Attending Physics after death.

In Director: After this ed in by the funeral di

Maryland 21215-0020

Baltimore,

To the Hospital o within 24 hours af To the Funeral Di completely filled I

13

State Registrar

Medical

29a, Cartifier

29b. Signature and title of certified

29c Licensa number 26492

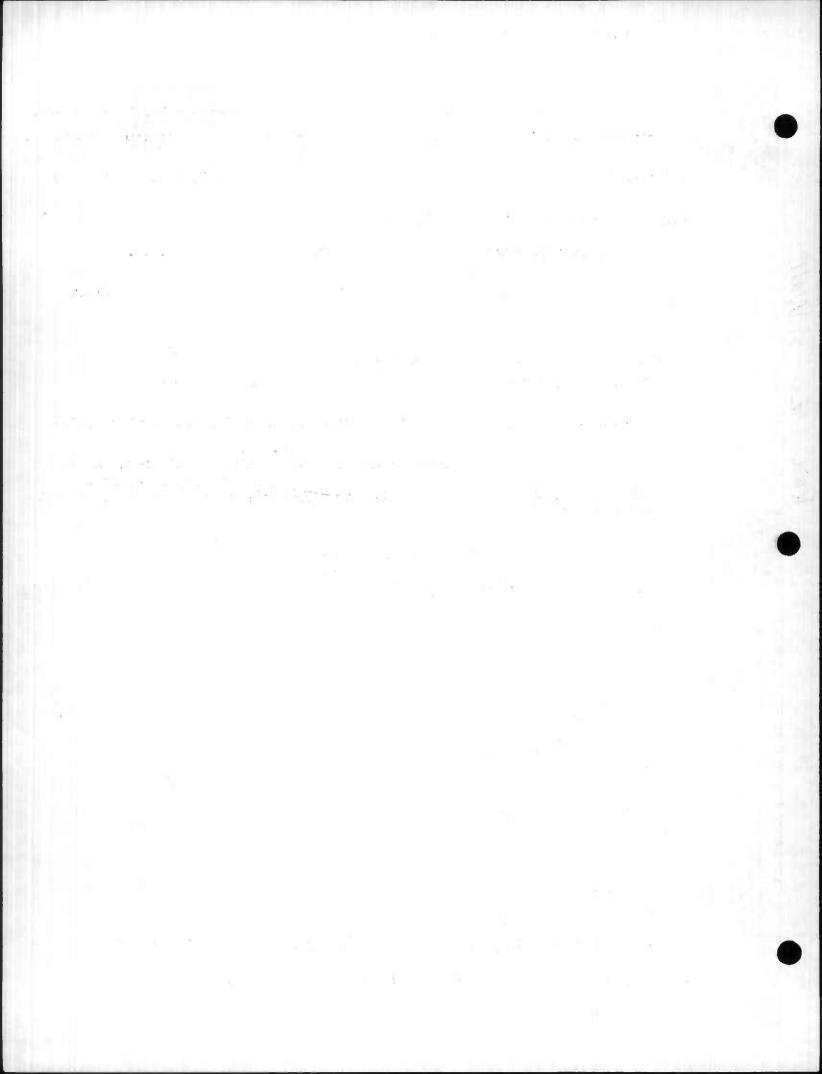
1 Seatifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place, and due to the causa(s) and mannar as stated.
21 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the causa(s) and mannar statad. 29d. Date signed (Month, Day, Year) 12,19.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riad Dakheel, m. D 4000 Mistels Wille Rd, Bowie, MD 207/6

31. Data filed (Month, Day, Yaar)

32. Ragistraris Signatura DEC 2 2 1998



#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

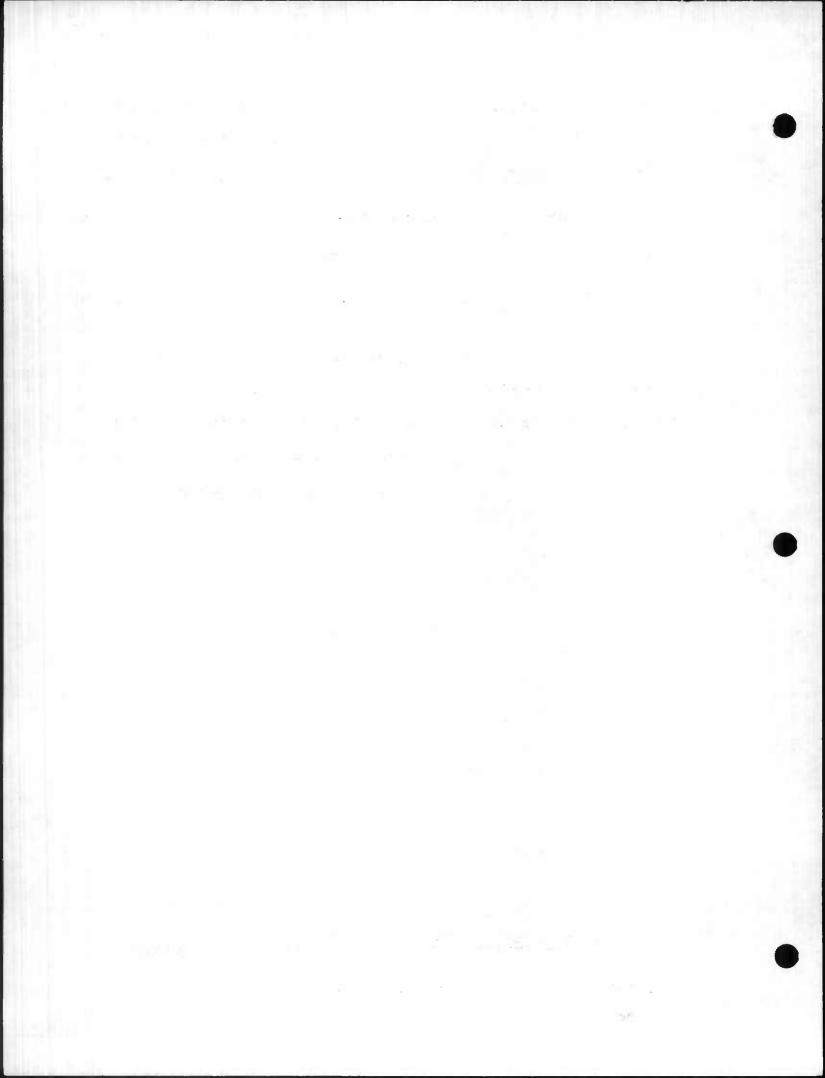
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death 79, 1998 **Physician** Helen В. December Weadon 1:20 am /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8730 D Street Chesapeake Beach Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Sex Birthplace (State or Foreign Country) **Funeral** 225 32 9145 1 M 2 TF 67 Director Apr. 11, 1931 VA Usual Residence of Decedent with the Meryland 10e. State 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menylan Department of Heelib and Mental thygiene. Important: If team 27 is marked other than "natural", or itema 23a or 28a-4 show any injury or other traumatic event, the Mexical Externice must be notified at 10d. Inside City Limita MD Calvert Chesapeake Beach Director XYas 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8730 D Street 20732 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Statua 14. Race - American indian, 1 ☐ Yea 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Buainess/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 12 Education secretary 17. Father'a Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Malden Surname) Be Breeden Henry 2 Mary Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston R. Weadon/spouse PO Box 344, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12-20-98 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (SMALL CELL) LUNG Physician CANCER WITH Immediate Cause (Final disease or condition resulting in death) /Medical Several Examiner month METASTASIS. Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 attending for use signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yan 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 168 1 Yes 2 No certificate TLIYES 2D No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Feesidence 8 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) 6 D - 025519 12-19-98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y Atul Shah, M.D., Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Maude Catherine Windsor 17, Dec. 1998 6:51 P.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9130 Southern Maryland Blvd. Owings Calvert 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Data of Birth (Month, Day, Year) **Funeral** 10 M 20 F Days Yrs. Director 217-66-0122 June 11, 1923 Maryland Usual Residence of Decedant death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits ehow 7 is marked other than "natural", or itema 23a or 28a-f ahov traumatic event, the Medical Examinat must be notified at Maryland Calvert Owings 1 ☐ Yas 2 No Director 10a. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 9130 Southern Maryland Blvd. 20736 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event. the 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯XNo Specify: Specify: þ 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Housewife Home 17. Fathar's Nama (First, Middla, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) Be John Francis Thomas Martha Ann F. Beatly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) V. Elvis Windsor (son) 9130 Southern Maryland Blvd., Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata DEC. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22,1998 Clinton, Maryland 4 Donation 5 Nother (Specify) Entombment Resurrection Cemetery 22. Nama and Address of Facility Lee Funeral Home, Calvert, P.A. 21. Signature of Funeral Sarvice Licensaa 8125 Southern MD. Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** immediate Causa (Final disease or condition resulting in death) /Medical Examiner Examiner patitis buriel-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician s the buriel Box 68760 The lew requires that the deeth certificate be Physician/Medical Due to (or as a consequence of): attending 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 94 à 1 Yes 2 No 3 Probably 4 Unknown certificate has been signed irector, page 2 should be de by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of VItal To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Hasidance 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 26b. Time of 28c. Injury at Work? 26d. Dascribe how injury occurred Certification: 1. Natural 5 Pending Invastigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 6 Could not be 26e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifian Medical 29b. Signature and tigle of certifier 29c. License number 29d. Data signed (Month, Day, Year) December 18, 1998 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Catherine Brophy, MD, 10845 Town Center Blvd., Dunkirk, Maryland 20754 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2.1 1998

**DHMH 16 Rev 6/95** 

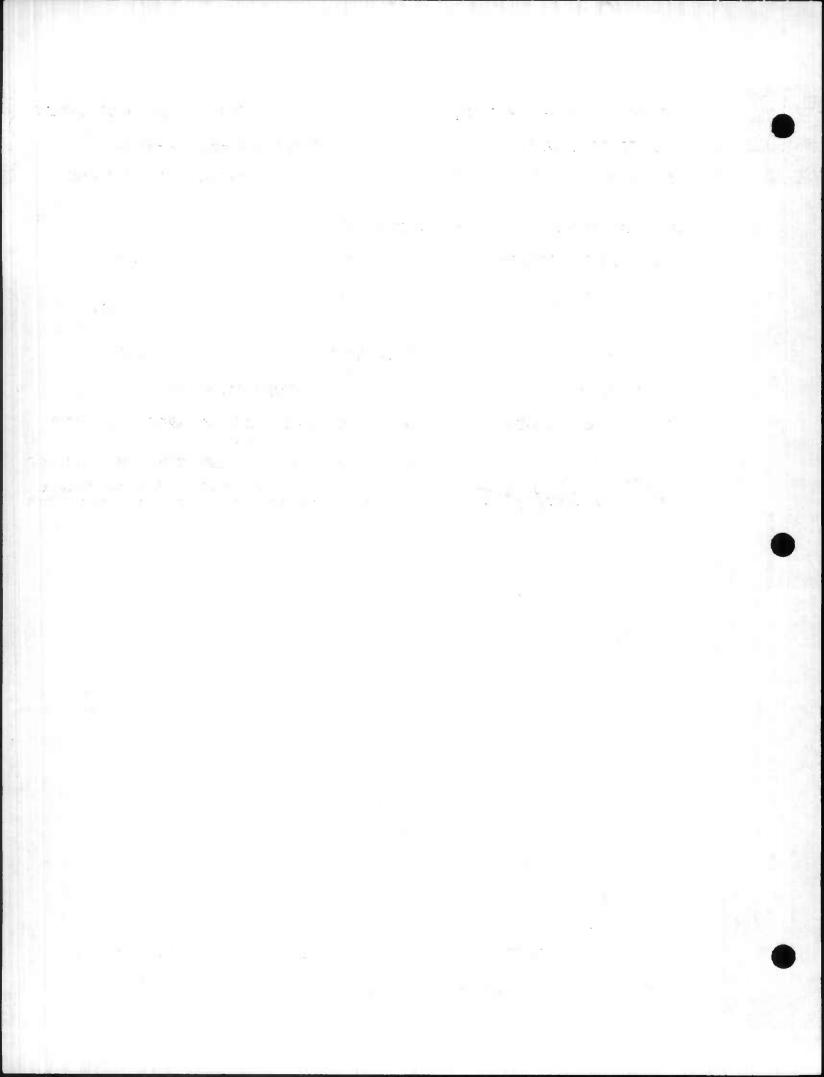
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State of Maryland / Department of Health and Mental Hygiene Q

Decedent's Nama (First, Middla, CLIFFORD HEN a. Facility Nama (If not institution, 204 WEST LAKE B. Social Security Number 074–16–4043  Jaual Rasidence of Decedent 10a. Stata 10b. County  MARYLAND CALVER 0a. Street and Number 204 WEST LAKE B. 1. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) 12  7. Father's Name (First, Middla, Later 12) DEWEY WALLACE 19a. Informant's Name/Relationship MAMIE V. WALLAC 10a. Method of Disposition 15 Burial 2 Cremation 3 4 Donation 5 Other (Specific Specific S	RY WALLACT giva street and number)  OULEVARD  S. Sex  1 T	a (In yrs. last birth 75  10c. City, Town PRINCE  Evar in U.S. Io W.W.II  16a. I  19b. 1  204	TREDERIC  TOT Location  FREDERIC  10f. Zip C.  206  13. Was Deceder if Yas, specify  1 Yas 35  Decedent's Usual C  Giva kind of work ifa. DO NOT use  UCK DRIV  Mailing Addrass (S  WEST LA	PRINCE F Yaar If Undar 24 H Days Hours M  K ode 78 Int of Hispanic Origin? Cuban, Maxican, Pu  No Specify: Decupation dona during most of w retired)  ER  18. Mothar's N  MYRTI  Street and Number or	(Specify Yas or No- arto Rican, atc.)  (Specify Yas or No- arto Rican, atc.)	Day R 19 4c. County of CALVE Year) 1923  Dg. Citizan of W U. S. 14. Race Black Specify: 16b. Kind of But TRUCK Maiden Sumanus	Yaar 1998 3 of Death RT 9. Birthplaca Country NEW YOF  10d. In 1 /hat Country? A American Ink, Whita, atc. WHITE sinass/industry	nsida City Limit □ Yas 2 🛱 N dlan,	
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Joseph /o	islan Jt		8125 SO	UTHERN MD	BLVD. OWI	NGS, MA			
23a. Part1. Entar ha disease, or co shock, or haart failura. List or	omplications that caused by one cause on each lin	tha death. Do no	t antar tha mode o	of dying, such as card	ac or respiratory srre	ist,	Intar	roximata rval Between at and Death	
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art II. Other significant condition	contributing to death bu	it not resulting in	ha undarlying cau	sa given in Part I.		bacco use con			
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5. Was casa ratarred to medical axaminar?	** ***				eath (Check only on	a)			
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	28a. Data of injur (Month, Day	y Year) 28b. Ti			28d. Describe ho	ow injury occurred			
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2 Accident invastigation	an Zoa. Placa or inju	iry - At homa, farr :. (Specify)	n, streat, factory, o	office	28f. Location (St. City or Town	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
2 Accident investigate 3 Suicide 6 Could no		t my knowledga, axamination and/	daath occurred at i or invastigation, in	tha tima, data and pia my opinion, daath oc	ce, and dua to tha ca curred at tha tima, da	ause(s) and mar ata and place, a	nnar as stated. and dua to tha	causa(s)	
2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Ex	aminar: On the basis of	tod		icense number	25	9d. Date signed	(Month, Day,	Year)	
2 Accident 3 Suicide 4 Homicide  1 Could no detarmin  29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	aminar: On the basis of	ted.	29c I						
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Yee **Physician** Mattie L. December 20 1998 3:00AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street and number) 4c. County of Deeth Examiner Randolph Hill Nursing Home Wheaton Montgomery If Under 1 Year if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Min Yrs 579-84-6402 90 Director Oct. 5 1908 South Carolina Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be noutled at 1 XYes 2 No Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 20906 13940 Alderton Road United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Orlgin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Meritei Stetus Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than \*n eny Injury or other traumatic event. In east Elementary/Secondery (0-12) College (1-4or 5+) 12th Elevator Operator Government 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be 0 Joseph Lowery Mattie Austen 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marie A. Tapscott - Daughter 13940 Alderton Rd., Silver Spring, MD 20906 20b. Piace of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State Washington National Cem. 12/28/98 Suitland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Sign ture of Funerel Service Licenses 22. Name end Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Per 1. Inter the disease, or complications that ceus of the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, show, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** myocordial enfarction /Medical Immediate Cause (Finei disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) certificate be execu Box 68760. Physician/Medical Due to (or as a consequence of) 88 USB 0 23b. Did tobacco use contribute to the cause of death? Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. detached signed by t 3 Probably 4 Ullakhown 1 Yes 2 No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy Completed page 2 has certificate 1 Tes 2 de 1 ☐ Yes 2 ☐ No Physiclen: director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Harsing Home 5 Residence 8 Other (Specify) Lo 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28h Time of 28c. injury ef Work? Certification: After Attending 1 Statural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò 1 Perifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

Hospital 24 hours To the Hosp within 24 hor To the Fune completely fi 3

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

29c. License number

009834

29d. Date signed (Month, Day, Year)

December 22, 1998

FARRAGUT AUG KEUSINGTON, MY 20895 3720

Registrar

(Check only one)

29b. Signature and title of certifier



Same?

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	JAMES WASHIN	ICTON					Month 12	Day 16	98 3:45 a		
al _	la Facility Name (If not institut		et and number)			4b. City, Town,	or Location of Dea				
_	Prince George'	s Hosp	ital			Cheverl	V	Prince	e George's		
	5. Social Security Number	6. Sex	7. Age	(In yrs. last birth	day) If Under 1 Yea		Hrs. 8. Dete of B		Birthpiaca (State or For Country)		
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-	10e, Street and Number			10g. Citizen of Whet Country?							
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	Marcel Washington Queen Mary Hayden										
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Deeth 3. Time of Deeth Month DEC. Clarence Branham 26, 1998 2:15 PM 4a. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore N/A 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. Hours Min. Birthpleca (Stata or Foraign Country) 6. Sax 8. Dete of Birth (Month, Day, Year) 1QM 2□ F Vrs 214-38-1295 MAR 5, 1940 Maryland Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21223 1812 W. Pratt St. USA 12. Wes Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yaer or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, Whifa, atc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Unknown Carpenter Carpentry 17. Fether's Neme (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Sumeme) Unknown Odell Brown 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Terry W. Branham – son 210 S. Harmison St., Balto., Md. 21223 20b. Plece of Disposition (Nama of cematary, cramatory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1/07/99 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Baltimore Washington CR. Laurel, Md. 22. Nama and Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. Fees , or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, fellure. List only one cause on each line. Ent to Approximete interval Between Onset and Deeth Immediate Cause (Finel diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Per II. Other significant conditions contributing to reath but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings valiable prior to complation of causa of death? 24a. Wes an eutopsy performed? 1 🗆 Yes 25. Was case referred to medical 26. Plece of Deeth | Check only ona) Other: 4 Nursing Home 5 Residence Other (S 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Munney Deeth 28d. Dascribe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? aturel 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 3 Sulcide 6 Could not determine 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcida 29a. Certifie certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as ateted.

Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

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To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by th

State Registrar

**Physician** 

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**Funeral** 

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after o Depertment of Health and Mertel Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examina

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Please Type or Print in Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Vaar 4 RAXIEN 2345 20 199x 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Death The OLD GEORGETOWN ROPO MONTGOMERY BOTHESOA If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthdey) Birthpleca (Stete or Foreign Country) 5. Social Sacurity Number Months Deys Hours 15 M 2□ F 68 Yrs. 218-24-0918 Oct. 8, 1930 Virginia Usual Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of Whet Country? 10a. Street and Number 7620 Old Georgetown Road 20814 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indien, Bleck, White, etc. 11 Maritel Status 1 ☐ Yes 2 ☒ No If Yas, Giva 1⊠ Nevar Married 2 Married 1 ☐ Yas 2 ☒ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Delivery Payrol1 12 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) William Baxter Nellie Baxter 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Evelyn Jean Mitchell/Niece 8365 Gatewood Drive, Jessup, Maryland 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) Jan. 7, Dete 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State Montgomery Crematorium, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signeture of Funerel Service Licensee or 42 M00198 23a. Part1. Enter ha disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death ACUTE MYOCERDIAL ENPARCTION Immediete Cause (Finel diseese or condition resulting in deeth) Due to (or as e consequence of): AMENIOSCUMLOTIC CAMDIOURSCULDA DISGOST Due to (or es a consequence of): DIBBETT MEWING Due to (or es e consequence of): 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred

Physician /Medical **Examiner** 

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Division of Vital Records,

or Attending Physician:

**Physician** 

Examiner

**Funeral** 

Director

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filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Nem 27 is marked other th any linry or other traumatic event, the once.

Baltimore, Maryland 21215-0020

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Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I.

25. Was case referred to medical 1 Yes 2 No

> 5 Pending Investigation 2 Accident 6 Could not be 3 ☐ Sulcida 4 Homicide

28c. Injury at Work? 1 Yes 2 No

28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and dua to the cause(s) end menner as stated.

Light Section 1. To the best of my knowledge, death occurred et the time, dete end plece, and dua to the cause(s) end menner as stated.

Light Section 2. To the best of my knowledge, death occurred et the time, dete end plece, and dua to the cause(s) end menner as stated.

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29c. Licansa number 015236

29d. Data signed (Month, Day, Year) DECEMBER 21, 1998

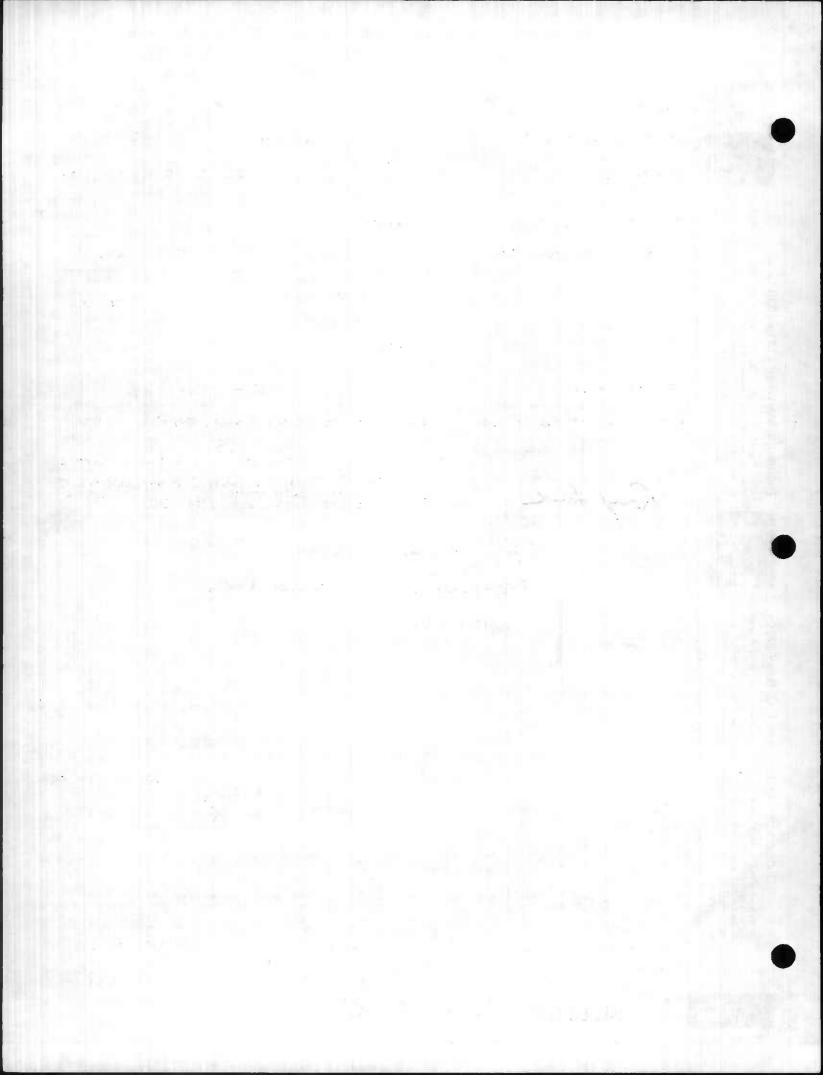
30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 11/25 POCKVILLE PIKE, POCKVILLE MO 20852

CARL I MARGOLIS, MO 31. Data filad (Month, Day, Year)

JAN 12 1999

32. Registrer's Signeture FRENCE

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 4 1 2 4 4 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Year **Physician** Month ELMER LLOYS GODDARD 1130 a.m DECEMBER 1998 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GOOD SAMARITAN BALTIMORE HOSPITAL H Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | April 27, 1924 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** XXM 2□ F Yrs. Director 235-28-6902 West Virginia Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at Director Dundalk 1 ☐ Yes 2 ☑ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1804 Kinship Road 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Status 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donnie Aaron Goddard Goldie Elsie Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline C. Goddard/Wife 1804 Kinship Road Dundalk, Maryland 21222 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Jan. 2,1999 Baltimore, Maryland 21. Signature of Monerel Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk , MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS

Due to (or as a consequenca of): 13 DAYS disease or condition resulting in death) **Examiner** Physician/Medical Examiner HYLOCOCCUS BACTEREMIA and I-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. the Due to (or as a consequence of): P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy DISEASE 1 Yes 2 No 1 ☐ Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Npatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

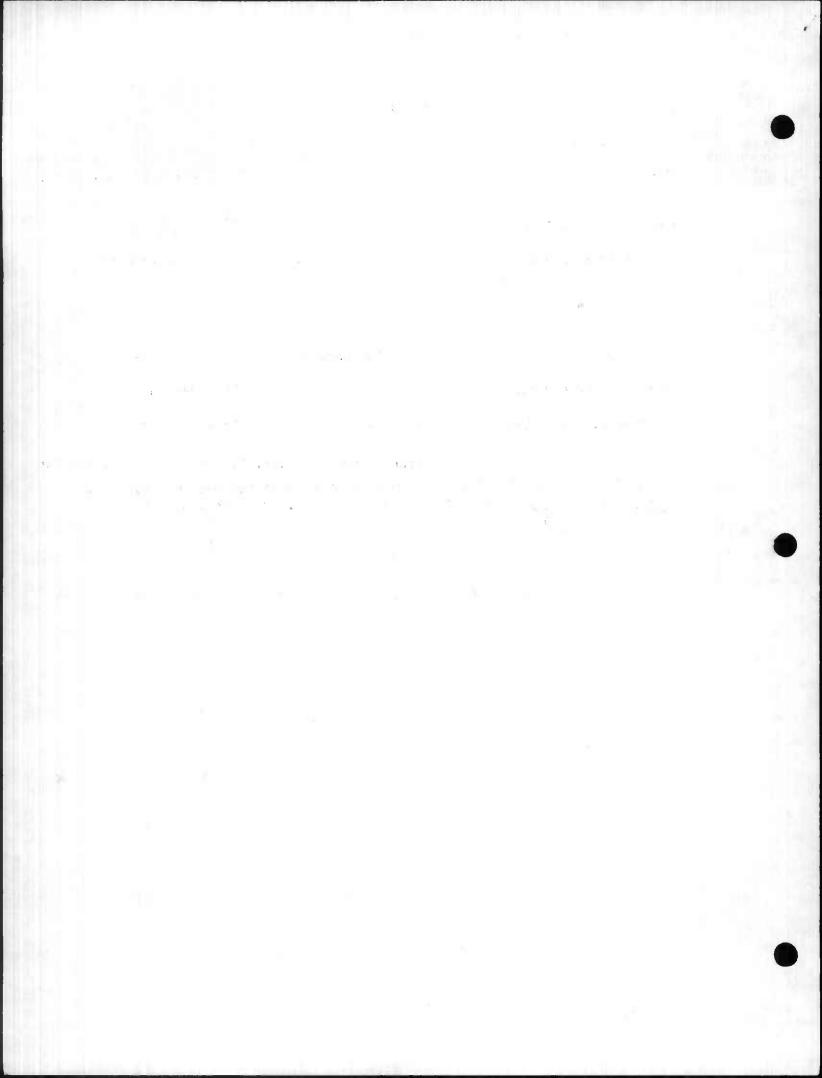
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) end manner steted. 29a. Certifier edical 29c. License number 29b. Signeture and title of certifler 29d. Date signed (Month, Day, Year) M. D P12126 DECEMBER 31 1998 6920 HONACHIE ROAD # 705 30. Name and address of erson who completed cause of deeth (Item 23a) (Type, Print) WALIS ABOUJAOUSE
31. Dete filed (Month; Day, Year) | 82. F M. D BALTIMORE M.D 21239

82. Registrar's Signatur

6 1999

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Registrar



Division of Vital

Physician/Medical Examiner The lew requires that the death certificate be signed by the attendible datached for u Completed certificate has Physician: Certification: To this funeral After t or Attanding death. ours after death. To the Hospital within 24 hours a To the Funeral C Hospital completaly

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29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

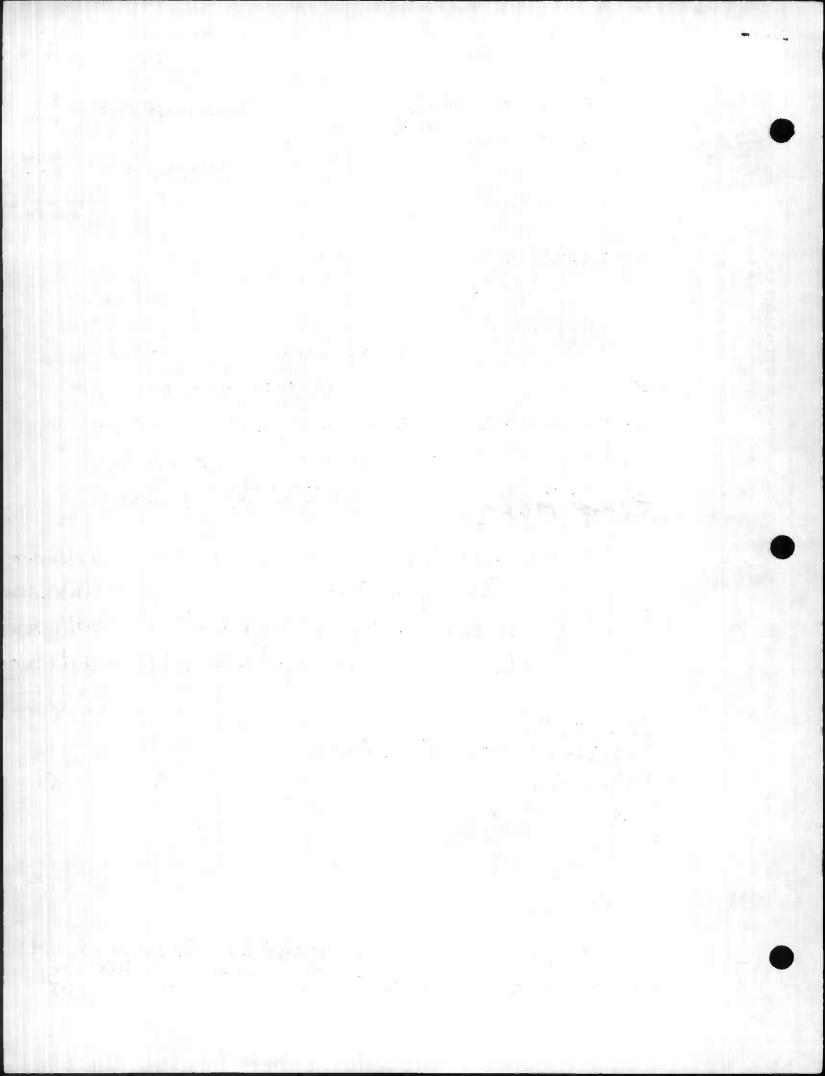
30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

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32. Registrer's Signeture

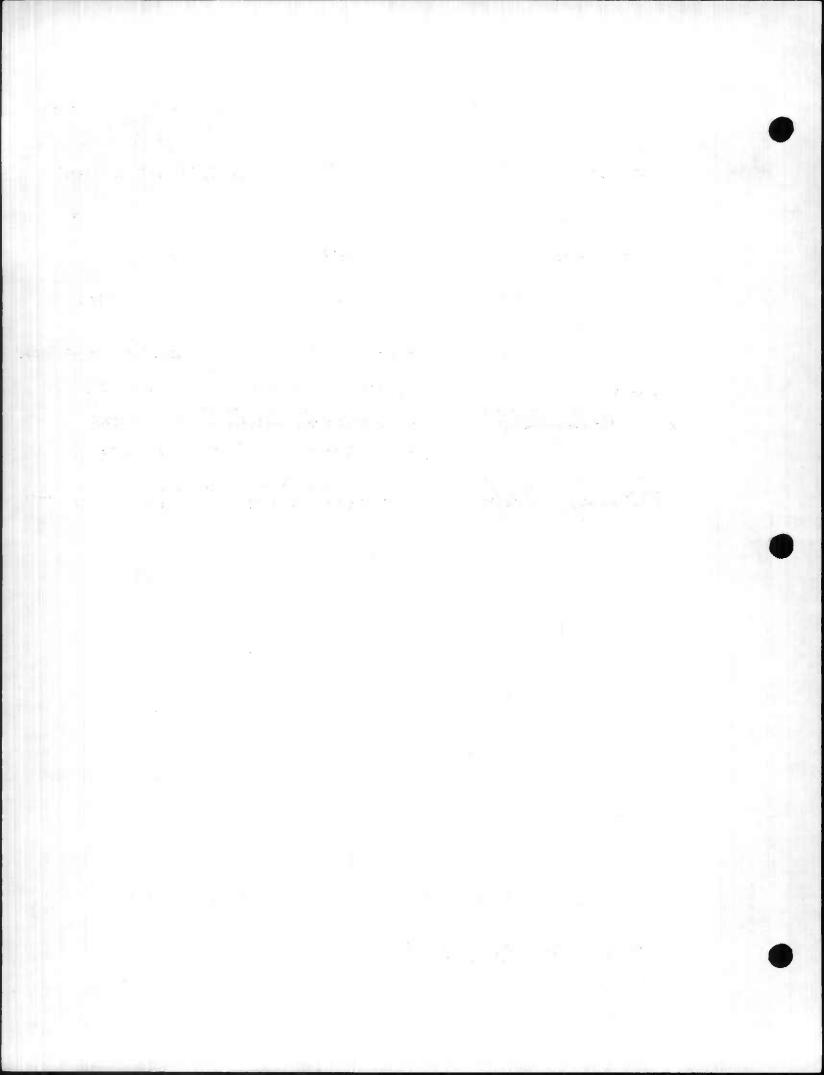
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° >	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1 ☐ Yes 2 🛣 No If Yes, Give Year or Detas:				Specify:	White		
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DHMH 16 Rev 6/95

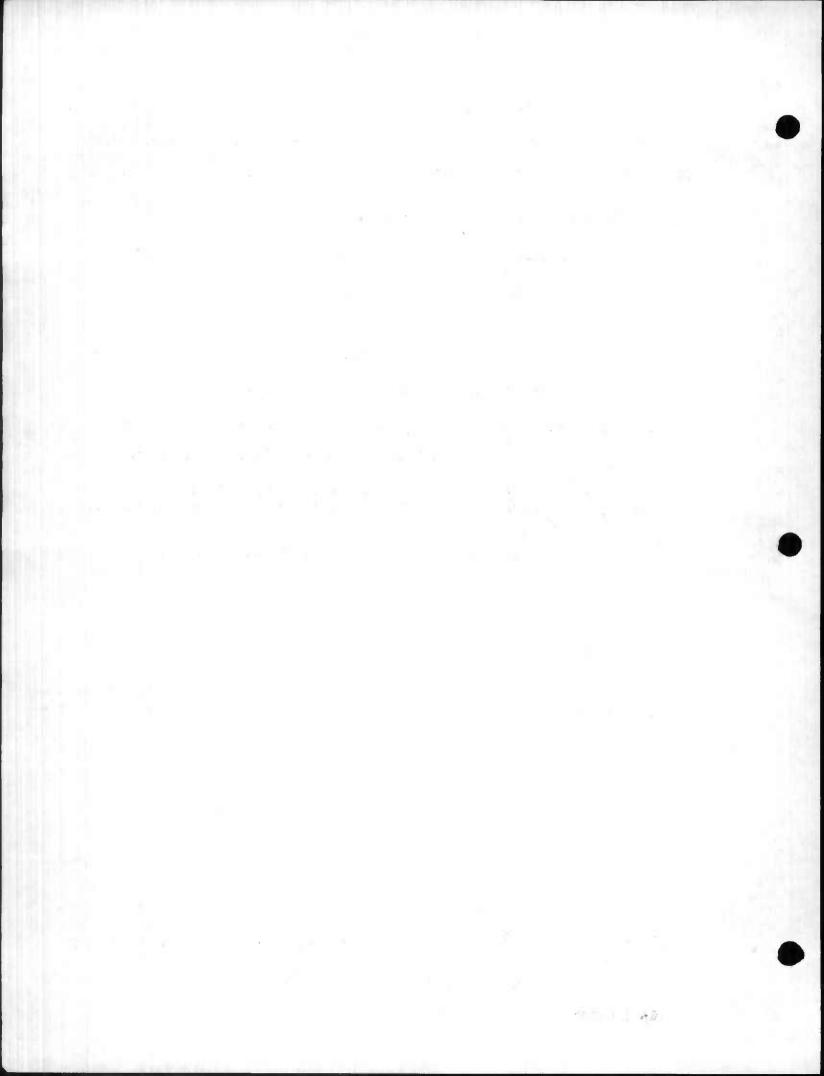


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 4 24 7

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Physician /Medical			Christi	ne M.	Peterso	on		December	23,199	98	1 P.M.
Examiner		4a. Facility Neme (If not institution, given	va street end number	)			4b. City, Town, or	Location of Deeth	4c. County	of Death	
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uneral irector			Sax 7. A 1□ M 2½ F	ge (In yrs.	1001 01111001/	If Under 1 Ye Months De			r. Year)	9. Birthple County Mary I	eca (Steta or Fo ry) and
ð til	-	10a. Stete 10b. County		10c. Ci	ty, Town or Locat	tion			-	10	d. Inside City L
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r than "natural", or items 23a or 28a4 show the Medical Examiner must be notified at completed by Funeral Director	2	11. Maritei Status  1 ☐ Nevar Married 2 ☐ Merried  3 ☒ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 ☐ Yas 2 ☑ If Yes, Give Yaer or Dates:	2 ☑ No ive 1 ☐ Yes 2 ☒ N		of Hispanic Origin? (Specify Yas or No Cuben, Maxican, Puarto Rican, etc.) No Specify:		No- 14. Race - Amarican In Black, White, etc.  Specify: White		tc.	
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em 27 inher tr		Robert G. Peterso	n Son		1902 C	edar F	Road Pasad	ena, Mar	yland 2	1122	
r of the	1	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. I	Piace of Dispositi cemetery, cremet	ion (Neme of tory or other	f plece)	Data	20c. Location -		
important: If Item 27 is marked other any injury or other traumatic event, once.  To Be C		4 Donation 5 Other (Specif		Mos	st Holy	Redeen	ner Dec.28	,1998	Baltimo	re, Mai	ryland
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DHMH 16 Ray 6/95



Examiner physician and the burial-transit Box 68760. 88 esn 0 signed by the a Division of Vital Records, P.O. peen page 2 certificate Hospital or Attending Physician: director. this funeral After after death.

**Physician** 

/Medical

Examiner

Directo

Funerai

by

Completed

**Funeral** 

Director

with the Marylar

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or Nema 23a or 28a-f show treumstic event, the Medical Examiner must be nothed at

I Hygiene. other than "natural", c

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy, Important: If frem 27 is marked othe any injury or other treumatic event, page.

**Physician** /Medical

Examiner

Physician/Medical

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Completed

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Certification:

edicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 Tes 2 No investigation 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

Armstrons 31. Date filed (Month, Dey, Year) DEC 3 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

14201 MD 32. Registrar's Signature

MD

Laurel 1K Dr #102 Laurel mo 20707 souls

29c. License number

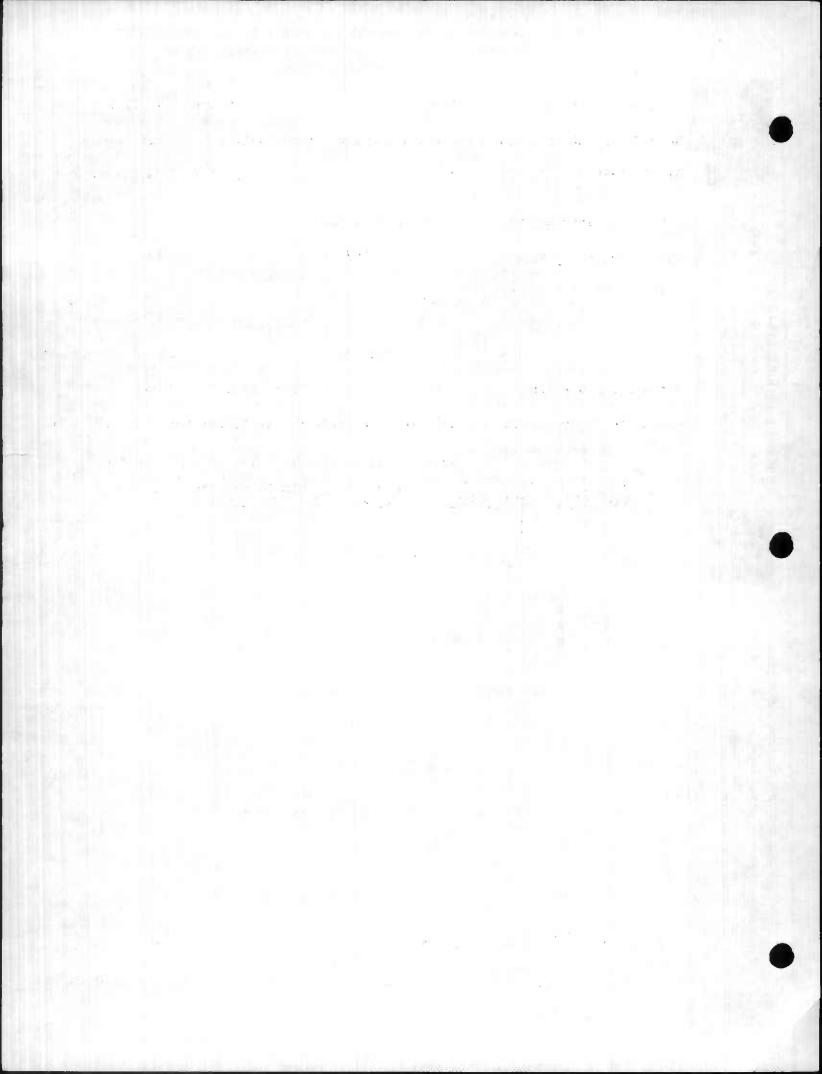
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29d. Date signed (Month, Day, Year)

24 hours a

To the Hosp within 24 ho To the Fune complately fi

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Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1998 9:07 pm Lucille Smith Anderson De-Es-mbe- 33, 199, cation of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 81 yrs 5. Sociai Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 200F Director 577-50-5469 Sept. 14, 1917 Indiana Usual Residence of Deceden the Menyland 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Md Howard Ellicott City 1 ☐ Yes 2 ☐ No Director 10g. Cifizen of What Country? USA 10e Street and Number 10f. Zip Code 6 3417 FONT HILLS DR. 21042 items 23s Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Merital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: Black à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Federal Government Department of Health and Mental Hygis important: If Item 27 is marked other any injury or other treumatic event, in one. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) 8 Arthur Smith Catherine Burden 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alan A. Anderson III 1915 Bronze Gate Blvd. Silver Spring, MD 20904 (Son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Gate of Heaven Cemetery 12-29-98 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi 11800 New Silver Spring, Md 20904 Hampshire Ave. Part 1. Enter the disease, or amplioritions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burief-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Completed by Physician/Medical for use as USB ached i PO Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 25 No 2 3 Probably 4 Unknown 1 Yee Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s certificate has The 1 Yes 1 □ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 □-N Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Accident 5 Pending investigation To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 8 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 24 D19935 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. SAMUGL 7610

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Dey, Year)

DEC 29 1998

32. Registrer's Signature

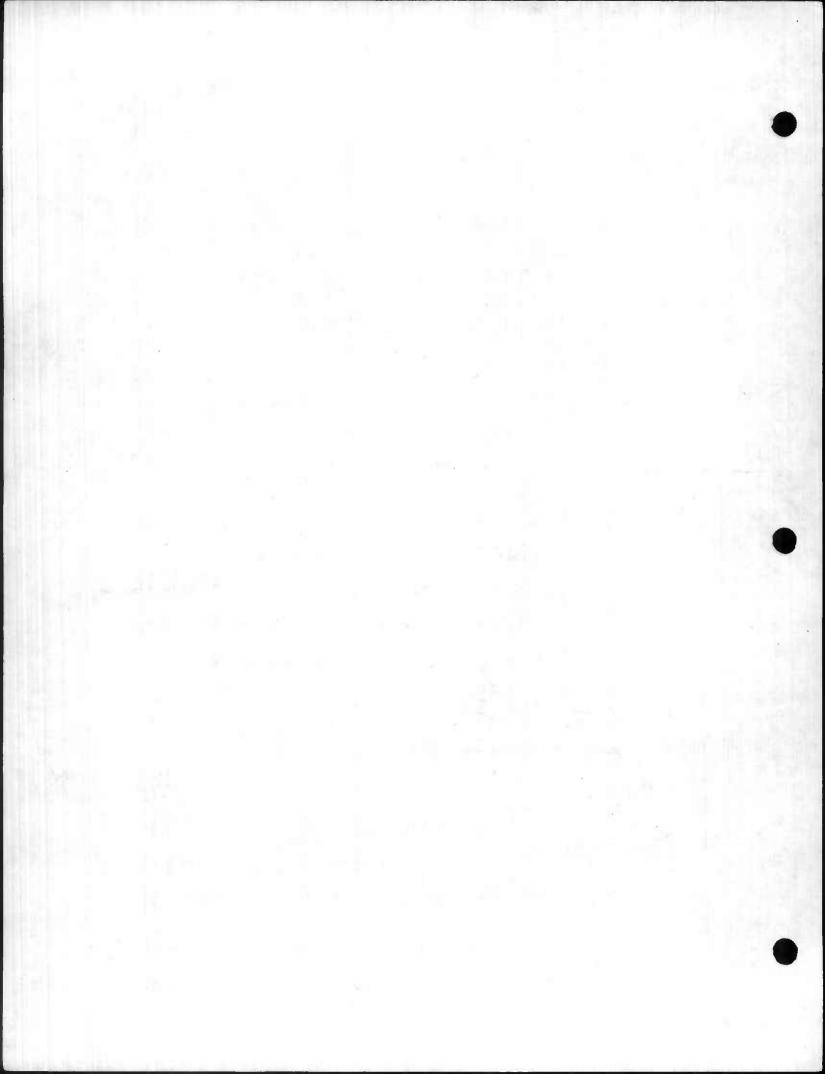
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MD 20912



#### Piease Type or Print in Biack Indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle | ast) 2. Dete of Deeth 3. Tima of Death Month **AUERBACH** DECEMBER 30, 1998 1:00 JUILTA 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not Institution, give street and number) HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 24 Hrs. 8. Date of Birth Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 10M 20F Months Deys 12.09.1913 85 MASS. 052.05.0532 Usuel Residence of Decadent 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 USA 6121 MONTROSE ROAD 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes 250 No Specify: 3 DWidowed 4 □ Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Eiementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) ISAAC MARY RIVKIN CUBEL 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) MARSHA FABEL/DAUGHTER 14120 FLINT ROCK ROAD, ROCKVILLE, MARYLAND 20853 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) STAR OF DAVID MEMORIAL G.1/5/99 N. LAUDERDALE, FLORIDA 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 se, or c implications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, in many one cause on each line. 23a. Pert1. Enter shock, or heert failu Approximete Interval Between Onset and Death e. METASTATIC CANCER (BRAIN, LUNGS) Due to (or as a consequence of): immediate Ceuse (Final disease or condition resulting in deeth) PRIMARY CARCINOMA OF BREAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of deeth? Part if. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was en eutopsy performed? completion of cause of death? TOYES ZXNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

if then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

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death

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permit. Pages 1 end 2 should be Department of Heelth and Menta Important: If Item 27 is marked any Injury or other treumstic ev

Baltimore, Maryland 21215-0020

attending physician end for use es the burial-frens 80 the signed by the ueed page 2 certificate hes this

Examiner Physician/Medical by Completed Be 10 funeral Certification: After t

that the death certificate be executed Box 68760. we The Physician:

Division of Vital Records, P.O. I or Attending Father death. n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in Hospital

> State Registra

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Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Magner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Phyeiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

NO )

1) 18084

person who completed cause of deeth (ijem 23a) (Type, Print) 30. Name and address of

VM.D. 6121 MONTROSE

32. Registrer's Signature RD, ROCKVILLE MD 20 852 31. Dete filed (Month, Day, Year)

3

1 Natural 2 Accident

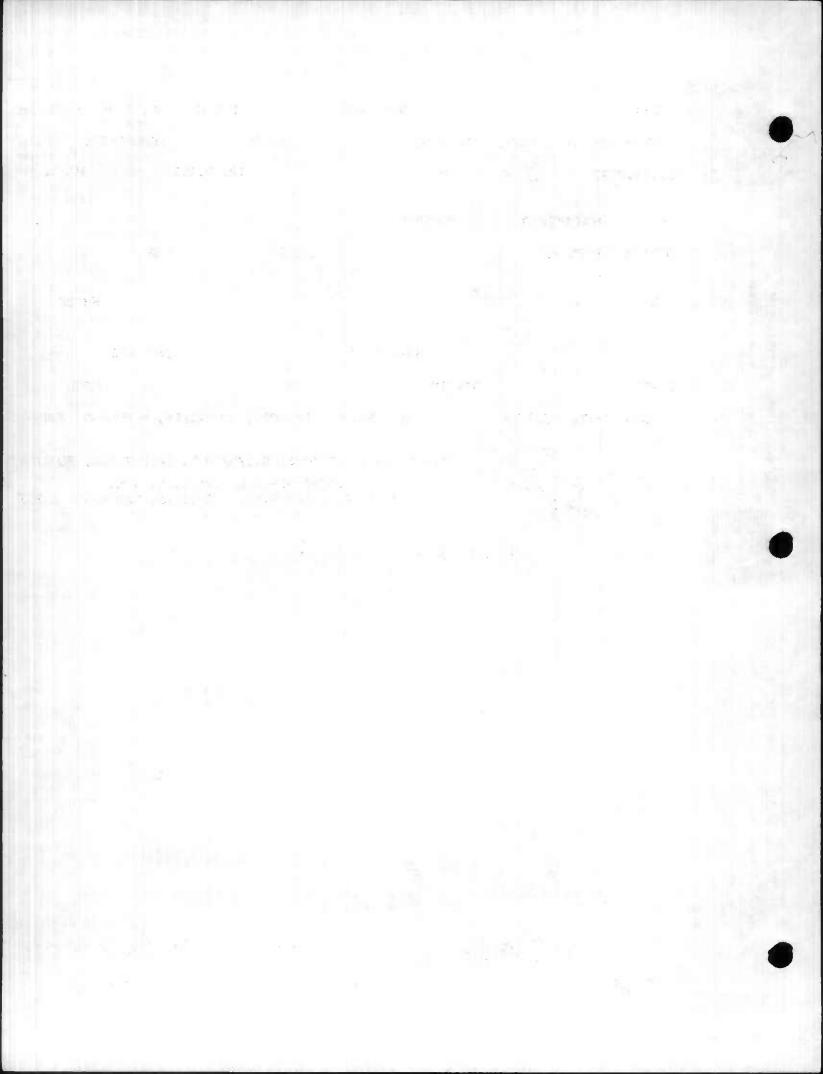
3 Suicide

29e. Certifier

4 Homicide

(Check only one)

To the To the To the F



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 25, 1998 Month Thomas Burch Athey Jr. 2230 December 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Heron Point Care Facility Chestertown Kent | If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth | Months | Deys | Hours | Min. | March 3 6. Sex 1 XM 2 ☐ F 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) 578-20-9396 Yrs. 93 1905 Usuei Residenca of Dacedent 10b. County 10c. City, Town or Location 10d. Insida City Limits XYes 2□No Maryland Kent Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1010 Heron Point 21620 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes À ANo If Yes, Give Yaer or Dates; Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 NWidowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Fertilizer Elementery/Secondary (0-12) College (1-4or 5+) Sales person/Board of Directors 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Thomas Burch Athey Sr. Avarilla A. Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dawn Marie Athey - Granddaughter 11708 Trophy Courts, Germantown, Maryland 20876 20b. Place of Disposition (Name of cerretery, cremetory or other place) December 26, 1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cramation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Chester, Maryland sapeghe Cremation Ctr., LLC 21. Signetura of Funaral Service Licentee 22. Name end Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. william L. King, Jr. 44-00937 130 Speer Road, Chestertown, Maryland 21620

23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory erfast, shock, or haert feilure. List only one cause on each line. Approximete Interval Between Onsat end Death fmmediete Ceuse (Finel CEREBROVASCULAR ACCIDENT disaese or condition resulting in daeth) ttherosclerosis Due to (or es e consequance of): Due to (or as a consequence of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobscco use contributs to the cause of desth? 1 Tes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

**Physician** /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the ettending physician and

is certificate has been signed by director, page 2 should be detac

filled in by the funeral

To the Hospital within 24 hours e To the Funeral Completely filled in

Be

10

Certification:

Medical

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10a. Stata

**Funeral** 

Director

Items 23a or 28a-f short instrument be notified at

"natural", or Item

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tal Hygiene.

. Peges 1 end 2 should be fill ment of Heelth and Mental H tant: if them 27 is marked oth jury or other traumetic even

permit. Pege Department o Important: If any injury or

Director

Completed by Funeral

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filed within 72 hours after death with the Marylend

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Ceuse (Diseasa or Injury that initiated events resulting in death) Last Physician/Medical þ Completed

exeminer'i

27. Menner of Deeth

1/⊠NetursI 2 ☐ Accident

3 Suicide

4 Homicide

25. Wes casa raferred to medical

1 Yas ZX No

24b. Were autopsy findings available prior to completion of cause of desth?

1 ☐ Yes 25 No

26. Plece of Deeth (Check only one) Other: Nursing Homa 5 Residence 6 Othar (Specify)

28c. Injury at Work? 28d. Dascribe how Injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end title of certifler 29c. License numbar 29d. Date signed (Month, Day, Year)

4158

Alber uns 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Helen Noble, 122 Speer Road, Chestertown, MD

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

28a. Dete of Injury (Month, Dey Year)

State Registrar 31. Dete filed (Month, Dey, Year) DEC 2 8 1998

5 Pending Invastigation

6 Could not be determined



many of money some state

#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene R Certificate of Death 2. Data of Death Month 1. Decedent'a Nama (First, Middle, Last) 3. Time of Death AN TAI December 16, 1998 ation of Death 4c. County of Death 700 4h City Town or Location of Death 4a Facility Name (If not institution, give street and number) BALTIMORE, City Tohns HOPKINS HOS Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Daya 326-32-0295 Yes 67 1931 Korea February 3. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Kent Chestertown 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 203 Rolling Road 21620 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 Yes 2X No 1 Never Married 2 Married 1 Yes 2√No Specify: Specify: Other (Asian) 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Gong Sun An So Goon Kwon 19a. Informarit's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sihn Ja An/Wife 203 Rolling Road, Chestertown, Maryland 21620 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Cemetery 12/19/98 Chestertown, Maryland 21. Signature of Funeral Service Licenses 22, Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the diseast, or conditional at caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, Approximate shock, or heart failure. List only one cause on each line. Intarval Between Onset and Death 1 MONTH Immediata Causa (Finat disease or condition resulting in death) PHEUMUNIA PRIJENDMUMAI 1 YEAR END STAGE TIVER DISEASE Sequentially list conditions if any, leading to immediat cause. Enter Underlying Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic avant, the Medical Exercise must be notified at each.

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medicai USB à Completed edical Certification: To Be To the Hospital or Atlandir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu

29a. Certifier

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

this

After

or Attanding

death.

Cause (Disease or Injury that initiated eventa resulting in death) Last	d	Dua to (o	r as a conseque	nce of):					
Part II. Other algnificant cond	litions contri	buting to death but not res	ulting in the und	erlying caus	a givan in Part I.	23b. Did tobacco usa co	antribute to the cause of death?  3 Probably 4 Unknow		
						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
25. Was case referred to medical					26. Place of De	eath (Check only one)			
examiner? 1   Yes 2   No		spital: Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing	Homa 5 ☐ Rasidence 6 ☐ Othar (Specify)			
Z LI MOCKOBIII	ding stigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c.	Injury at Work? 1 Yas 2 No	28d. Dascribe how injury occur	Dem		
	eld not be ermined	28a. Place of Injury - At he building, etc. (Specif	ome, farm, stree y)	t, factory, o	ffice	28f. Location (Street and Number City or Town, State)	ber or Rural Route Number,		

Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

| Wedical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licensa number

RES-000

BALLIMURE MARYIMAD

29d. Data signed (Month, Day, Year)

PECEMBER 1998

21787-9106

State Registrar

29b. Signature and title of certified

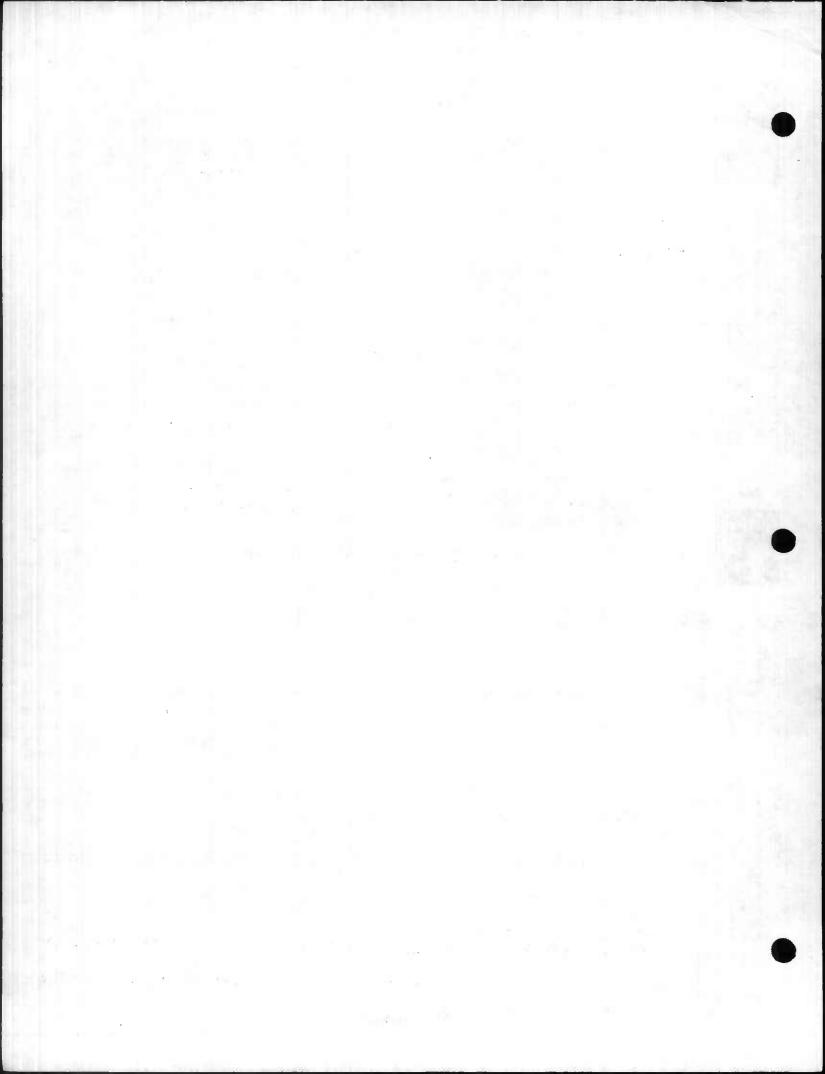
JAMES EDWARD BEHL 600 HORTH WOIR ST 32. Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMBROENCY.

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State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month RUTH HART BERTUCH DECEMBER 27,1998 3:00PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** POTOMAC VALLEY NURSING HOME ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 9. Birthpiace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 X F 216-40-6969 Vrs 85 Director DECEMBER 1,1913 ILLINOIS Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MARYLAND MONTGOMERY ROCKVILLE Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 POTOMAC VALLEY ROAD 20850 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes ZNO Specify: WHITE by Specify: **3**CWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Coilege (1-4or 5+) **EXECUTIVE SECRETARY** NEW YORK BLOOD CENTER 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H Is marked ou Be EDSON B. HART LOUISE HOWELL 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Clty or Town, State, Zip Coda) permit. Pages 1 and 2: Department of Health at Important: If Itam 27 is any injury or other tracents. PENNY HUGHES (DAUGHTER) 6219 HIDDEN CANYON ROAD CENTREVILLE VA. 20120 20b. Piace of Disposition (Name of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MOUNT COMFORT CREMATORY 12/29/98 ALEXANDRIA, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral 87 22. Name and Address of Facility

AFFORDABLE FUNERAL SERVICES 2230 GALLOWS ROAD #110 DUNN LORING VIRGINIA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. physician certificate be Physiclan/Medical the Due to (or as a consequence of): 98 USB 0 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? the 3 3 □ Probably 4 Nunknown 1 Tyes 2 No signed t Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen has paga certificate 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) 200 Other: 4 ursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Matural 5 Pending death. investigation 1 Tes 2 □ No 2 Accident Director 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide in 24 hous. The Funeral Directified in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

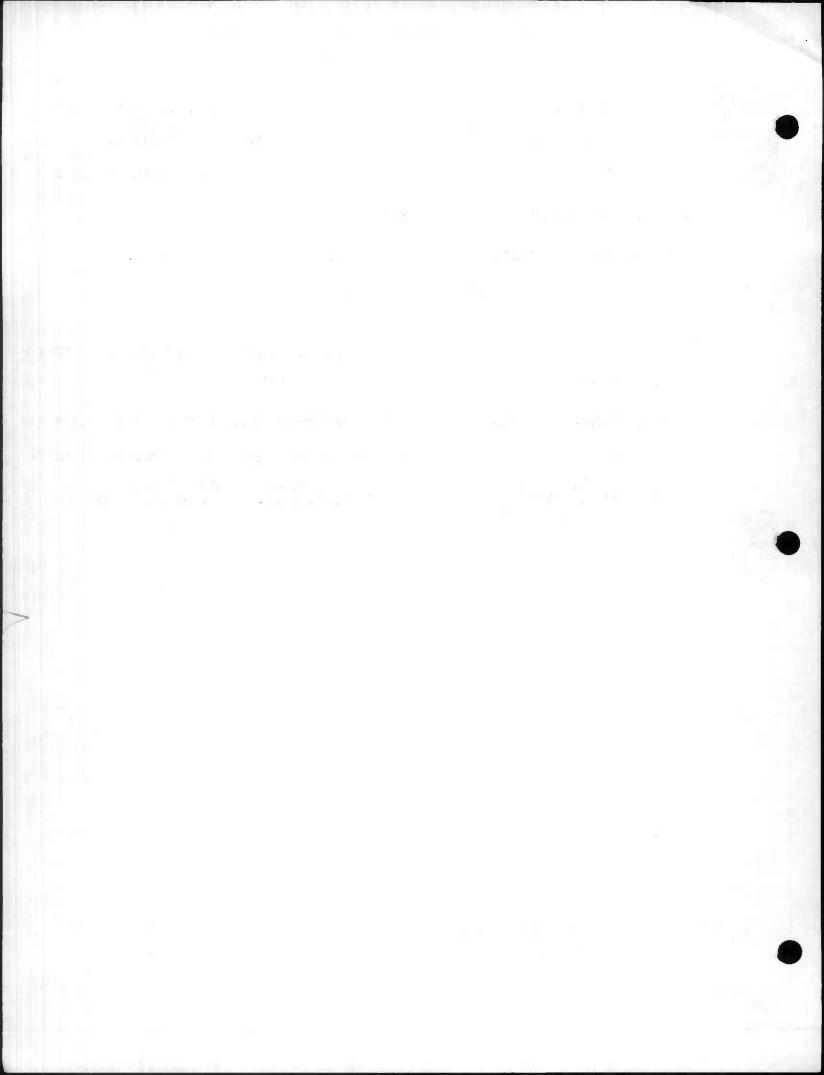
32. Registrar's Signature

1998

DR SILVER SPRING

Registrar

State



State of Maryland / Department of Health and Mental Hygiene 9 8

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** JOSEPH JACOB BOGART 1998 DEC 23 3:46 PM /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Deys Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral**  Birthplace (State or Foreign Country) Deys 18 M 2□ F 76 Yrs. Director 22, 1922 085-16-5609 Vermont Usuei Residence of Decedent the Marylend 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. inside City Limits Director Maryland Montgomery Chevy Chase 1⊠Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20815 United States 4712 DeRussey Parkway death 1 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. hours after 1 Never Married 2K Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 Widowed 4 Divorced Yeer or Detes:1943-1965 White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) Department of Defense Engineer 5+ other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 12 should be fi and Mental H Grace Federal William A. Bogart 2 permit. Peges 1 end 2 sh Department of Health and Important: If Item 27 ia m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 4712 DeRussey Pkwy., Chevy Chase, Maryland 20815 Rita F. Bogart/Wife 20b. Pleca of Disposition (Name of cemetery, cremetery or other piece) Jan. 13, 1999 20a. Method of Disposition 20c. Location - City or Town, Stete 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Neme and Address of Fecility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Avenue Chase, Inc.
Bethesda, Maryland 20814-3501
Approximate 21. Signeture of Funeral Servica Licensee M00198 CA 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teiture. List only one cause on each line. interval Bet Onset and Deeth **Physician** /Medical Immediate Cause (Finet diseese or condition resulting in deeth) SEPTIC SHOCK Examiner Due to (or es e consequence of): Examiner MULTI ORGAN SYSTEM FAILURE requires that the death certificate be executed Sequentielly ilst conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last pue Due to (or es e consequence of): buriel-tran Box 68760, physician CUSHINGS SYNDROME Physician/Medical the Due to (or es e consequenca of): for use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peen The law page 2 s 1X Yes 2□No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: director 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitei: 1X inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 28e. Date of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending investigation 1 X Naturei death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendition within 24 hours effer death.

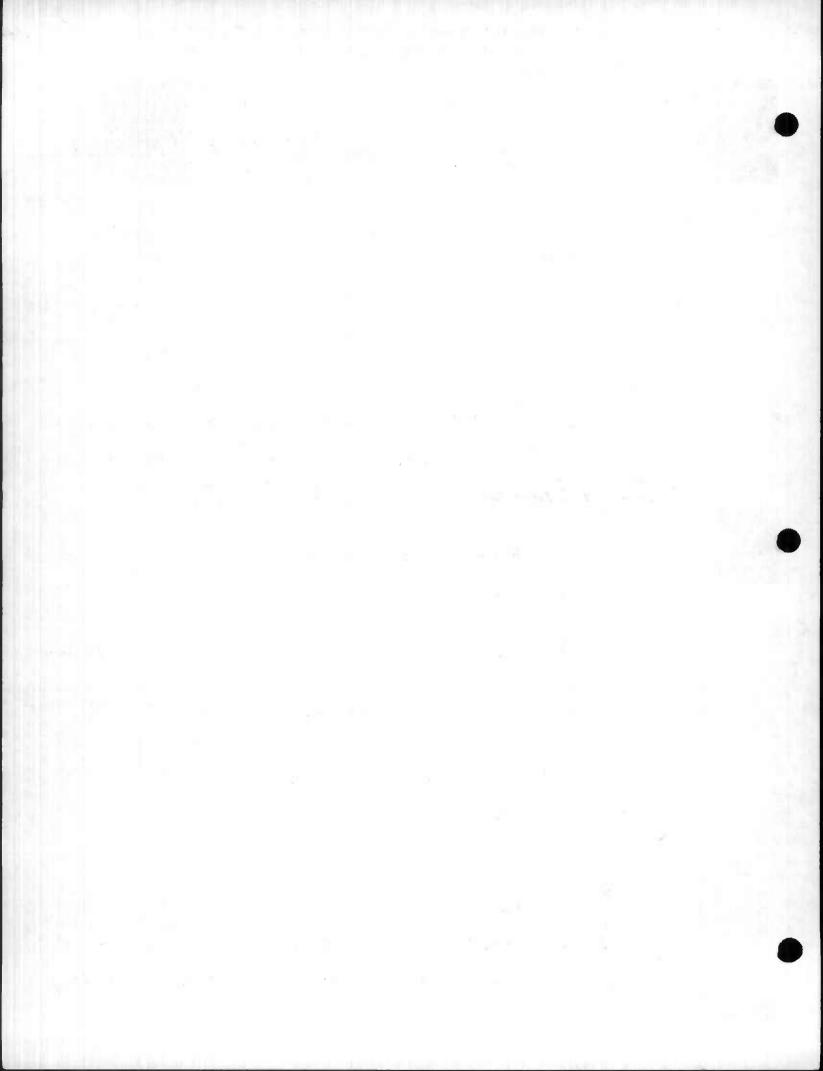
To the Funeral Director: A completely filled in by the forms. 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Pieca of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier 1🙆 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) end menner stated. 29b. Signeture and file of cartifier 29c. Licanse number 29d. Dete signed (Month, Dey, Year) December 28, 1998 MO x MD-000030545 (DC) DAC NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) BETHESDA MD 20889-5600 RAYMOND PUMAREJO, LCDR, MC, USN 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State DEC 3 0 1998 Registrar

DHMH 16 Rev 6/95



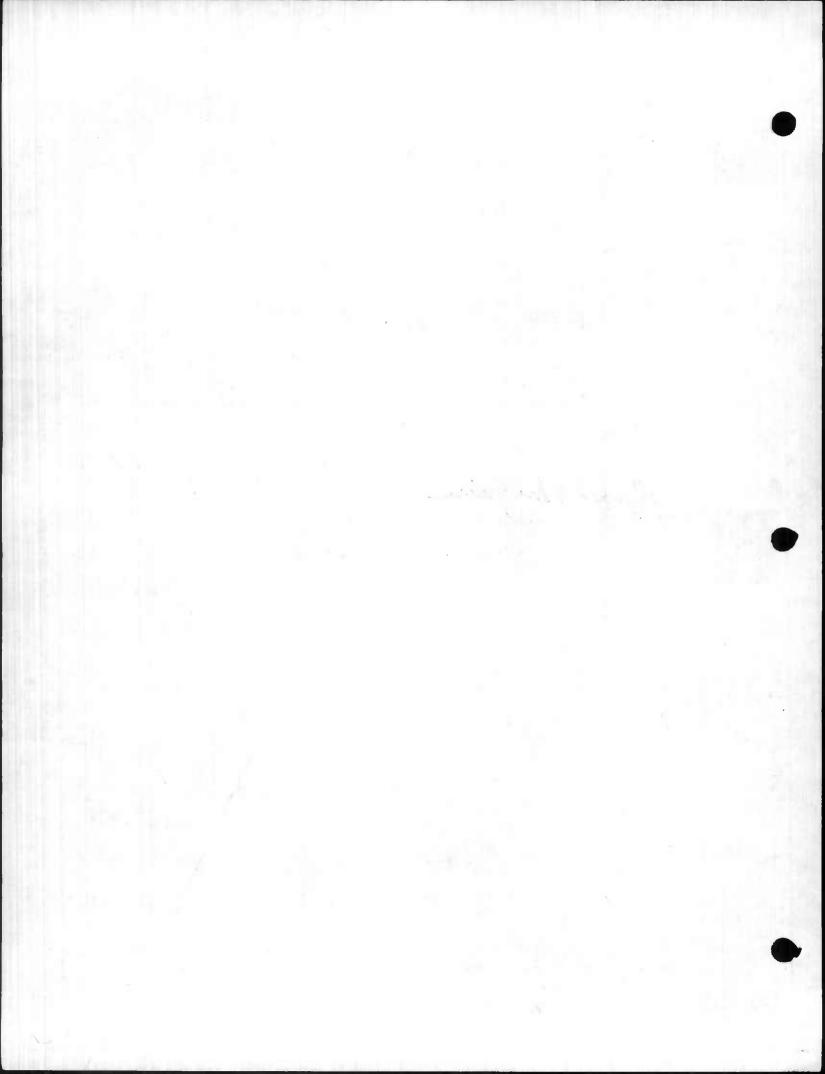
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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7	Examir		4a. Facility Name (If not institution, give st	reet and number)		41.0	4b. City, Town, or I		4c. County	of Death	-
				tom:tal		E	Silvers			tgom	eng
	Funeral		5. Social Security Number 6. Sex	7. Aga (In yrs.	^	If Under 1 Year Months Days		8. Dete of Birth (Month, Day,	Year)	9. Birthple	eca (Steta or Foreign
	Director		773-20-8631	" 201 /	9 Yrs.		1 2 2 1 1 1	Feb. 19,1			Dakota
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Maryland	2 sho		19a. Informant's Name/Relationship (Type	(daughter)	19b. Meilir	ng Address (Street	t end Number or Ru	ral Route Number,	City or Town,	Stete, Zip (	Code)
6	is 1 and 2 should be filed withing Hygiene. I Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M		Deborah Ann Brokenr	ope	1108	Oakview I	Drive Si				
Baltimor	80 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Re		cemetery, crer	netory or other ple	ece)	2/31/98 2	Oc. Location -	City or Tow	n, Stata
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Bal	Departm Importar any injur		21. Signeture of Funarel Service Licenses			2. Name end Addra ancis J.	ass of Facility Collins	Funeral H	ome. I	nc.	
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Si	Attending or death. ector: After by the fune	Icat	2 Accident Investigation 3 Suicide 6 Could not be	29a Place of Injury At h	ome form etc		]Yes 2□No	28f. Location (Stre	ot and Numb	er or Bural	Pouts Number
Division	or A efter Direct	Certification:	4 ☐ Homicide datermined	28a. Plece of Injury - At he building, etc. (Specil	fy)	eat, rectory, ornica		City or Town,	State)	er or marar	House Number,
	spital sours nerai		29e. Certifier 1 Certifying Physic	ian: To the best of my kno	owledge, death	occurred et the ti	ime, dete end piece	end due to the cau	usa(s) end ma	nner es sta	ited.
	To the Hospital within 24 hours of To the Funeral I	edical	(Check only 2 Madical Examina one)	r: On the basis of axamina and manner steted.	ation end/or in	vestigetion, in my	opinion, daath occu	rred at tha tima, dat	a and place, a	and due to t	the ceuse(s)
	To the Hospital or Attendit within 24 hours effer death.  To the Funeral Director: A completely filled in by the fu	×	29b. Signature and title of entifier			29c. Licens	sa number	29	d. Date signed	d (Month, D	ay, Year)
	10		1/1 (kha 2.	dato In		Do	44120	D	ecembe	~24	1998
	10		30. Neme end eddrass of person who com	plated cause of death (Item	m 23e) (Type,		- • •				
			Takas L. Satu	, MD. 148	116 ph	ysicians	s Lane.	Site 15	-, Rod	ev- 11	Maryland
F	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrer's Signe		low	61				



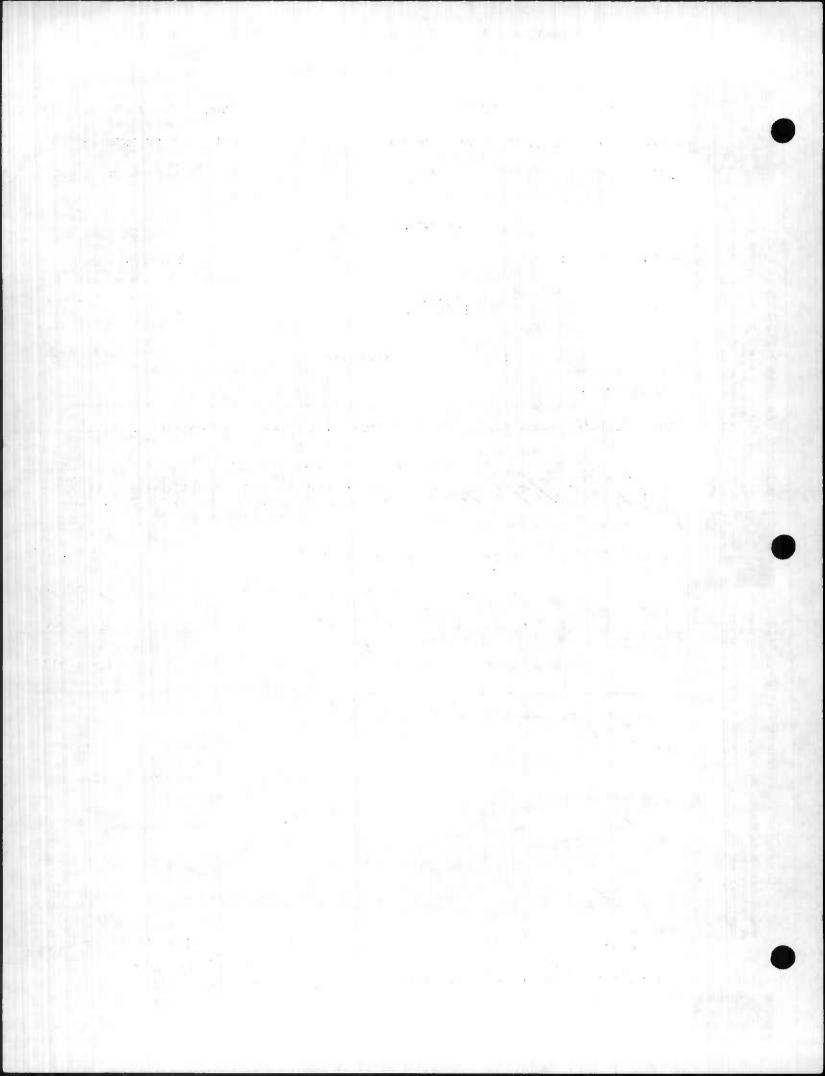
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Dec 23,1998 Physician David 04:00am /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. June 18, 1934 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Washington, D.C 1X M 2□ F 64 Yrs. Director 577-44-6127 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at XIX Yes 2 No Maryland Prince George's Directo Adelphi 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1906 Wooded Way 20783 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No 11. Merital Stetus permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" — any injury or other traumatic event. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dave Brown Wine and Elementery/Secondary (0-12) College (1-4or 5+) Entrepreneur/ Owner 12 Liquor Store 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William David Brown Ruby Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Brown /son 11112 Lake Arbor Way Mitchellville, Md. 20721 ace of Disposition (Name of Date 20c. Location - City or Town, State 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Mt. 12/28/98 Washington, D.C. 22. Name and Address of FacilityMcGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Wash., D.C. 20012 21. Signature of Funeral Service Licenses ther the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, the heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finei non-small ear 5 cell disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) USB 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown neumonia by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To 1 Yes 2 No 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturei 5 Panding Z Accident Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier D34590 12-23-1998 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried. MD. Kaiser Office, Holy Cross Hospital, address in Hem 4. 32. Redistrer's Signeture 31. Date filed (Month, Day, Year) **DEC 28** Registrar



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Examiner		MARINER					CENTE	R		ER SE			MONTG		RY	
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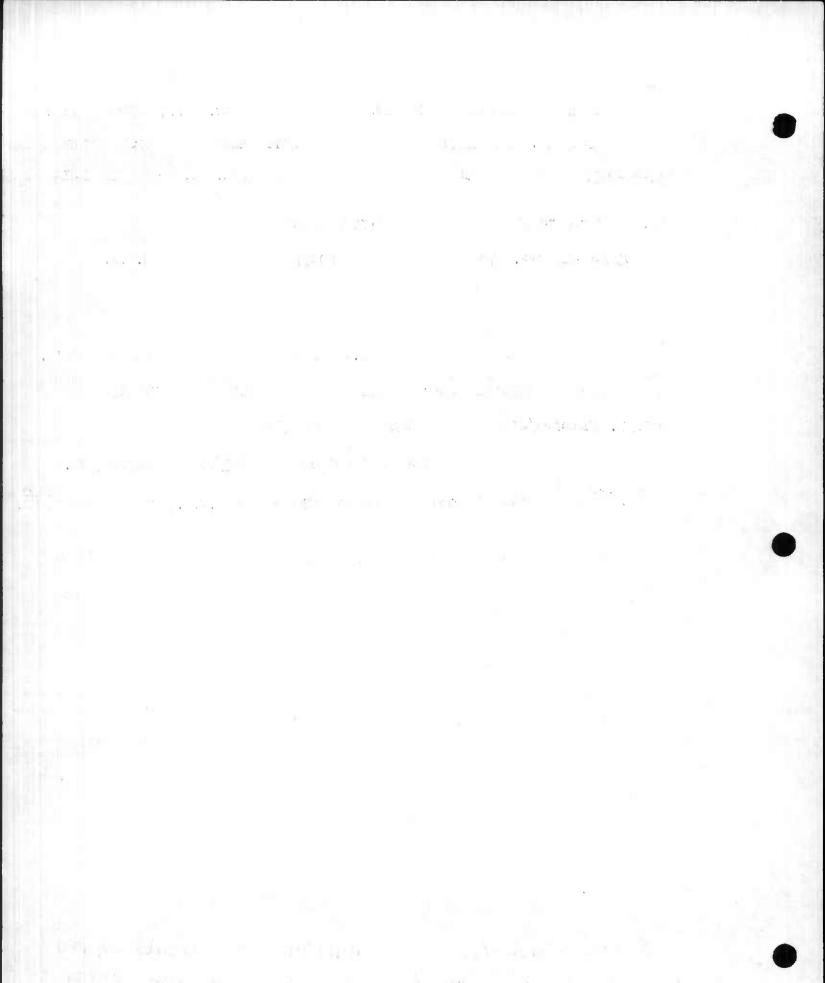
Registrar



State of Maryland / Department of Health and Mental Hygiene 9

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		31. Dete filed (Month, Dey, Year)	32 Ba	gistrer's Sign									

DHMH 16 Rsv 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 250 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death December 22, 1998 Robert BURGER 3:06 pm 100 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Route 75 @ Price's Distillery Road Ijamsville Frederick If Under 1 Yaar | If Undar 24 Hrs. 8. Date of Birth Month Bay, Year) FEB.17, 1980 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 6. Sax 1 MM 2 F Days Months Hours MARYLAND 217 98 9964 18 Usual Realdence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No MONTGOMERY GERMANTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12732 SESAME SEED COURT 20874 UNITED STATES 13. Waa Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates: 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dorse during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LABORER WAREHOUSE 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) ROBERT L. BURGER SHANNAH J. DOVE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12732 SESAME SEED COURT, GERMANTOWN, MD. 20874 SHANNAH J. DOVE-HASH, MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from State PARKLÁWN CÉMETERY 12/28/98 ROCKVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MURTEL HOBERBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disersa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final diseese or condition resulting in death) Multiple Traumatic Injuries Immed Due to (or as e consequenca of): Sequantially list conditions, if any, laeding to immadiate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4\square}$ Nursing Home $_{5\square}$ Rasidence $_{8}$ MOther (Specify) Roadway1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury Year) Dec 22,1998 28b. Time of Injury Year) 2:55 p 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Deeth 5 Pending Rear-seat passenger in car/ truck collision 1 Natural 1 ☐ Yes 2 X No investigation 2 K Accident

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

edicai

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

permit. Pages 1 end 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiena. Important: If item 27 ie marked other than "natural", or itema 23a or 2 any injury or other treumatic event, the Medical Examples or the page.

Baltimore, Maryland 21215-0020

Director

Funeral

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luneral

that the deeth certificete be executed or Attending Physician: after death. Director: After this certifica 2 A 24 hou. the Funeral Dis-

Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 hos To the Fune completely fi

State

Registrar

Distillery Rd, Ijamsville, MD

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and manner es atlated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. 29b. Signeture and titla of certifier were

29c. Licansa number D35164

29d. Data signed (Month, Day, Year) December 23, 1998

281. Location (Street and Number or Rural Route Number, City or Town, State) Route 75 & Price's

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

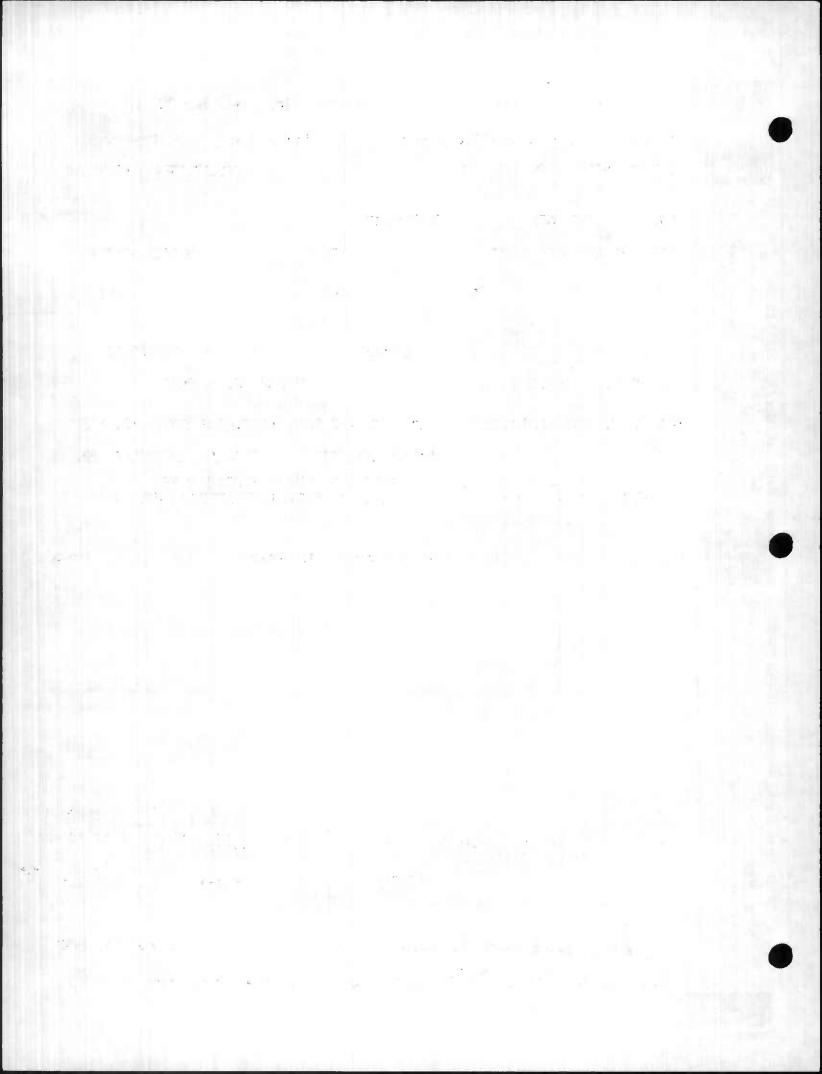
MD, 1080 West Patrick Street, Frederick, Maryland 21703 Andrew Zarick, Jr,

6 Could not be determined

32. Registrar's Signeture

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

Street



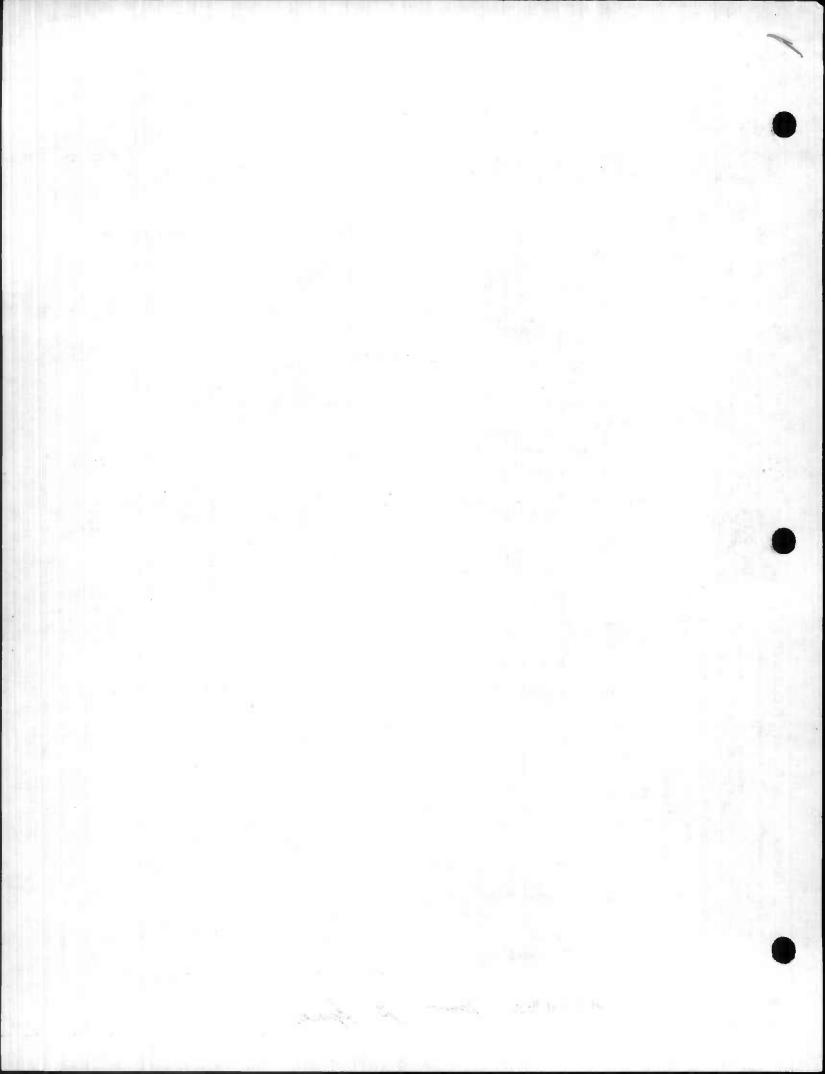
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PON BRIDGE	Certificate of Death	0 0	-5

UNKNOW	WN 98	-287 ANTHONY GORD		aryland /	-	nent of licate of	Health and I Death	Mental Hy	giene 9	} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1260				
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	aminer	4a Fecility Name (If not institution, git GLEBE ROAD/400 Y			VILLE R	OAD	4b. City, Town, or EASTON	Location of Deat	th 4c. County TALB	y of Death OT					
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and w	ы	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Locatio	n				11	Od. Inside City Limits				
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		8013 Ruby Harriso	on Rd.			21612			U.S.A.						
r deeth	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was I	Decedent of a specify Cul	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No o Rican, etc.)		ce - Americ					
21215-0020 d within 72 hours effer plene.	r, re Medical Examina Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divivorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No	101	res 2 No	Specify:		Specif	y: Whi	te				
72 h		15. Decedent's E (Specify only highest gr		10	6a. Decedent's (Give kind	of work done	during most of wor	rking	16b. Kind of B	usiness/Inc	lustry				
within than	e ld mo	Elementary/Secondary (0-12)	College (1-4or	5+)		OT use retire	90)		G C -	10,700					
Hygiel other	Be Co	17. Father's Name (First, Middle, Last	)	1.	Waterm		18. Mother's Nar	ne (First, Middle	Seafo						
Z o z z		Gordon Lee Br				Sandra	Sue Br	does		*					
faryian 2 should be end Mentel	treumatic To	19a. Informant's Name/Relationship	- 0	1	9b. Mailing Ad	idress (Stree	et and Number or Ru		-	, State, Zip	Code)				
	4	Sue B. Bridge Mother P.O. Box 50, Bozman, Maryland 21612													
nore	ry or other	20a. Method of Disposition  1 Nurial 2 Cremation 3 L  4 Donation 5 Other (Speci		ceme	of Disposition stery, cremator nan Cem	y or other pla		Date . 1998	20c. Location						
Baitim pemit. Pa Department Important:	eny injury once	21. Signature of Funeral Service Licensee  Advisor 2. Service Licensee  22. Name and Address of Facility  Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland													
Physic /Medi Exami	ical ner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			Inju	e mode of dy	ing, such as cardia	or respiretory	errest,	Waryı	Approximate Interval Between Onset end Death				
10 0	\$ B	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		a consequence										
X e	N N		d												
P.O.	deteched for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.									bably 4 Unknow				
Sords requires	Completed by							24a. Was	an autopsy ormed?	ava	ere autopsy findings allable prior to mpletion of cause death?				
	Con							15	kes 2□No	15	ZYes 2□ No				
of Vital IPhysician: The	To Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)						
- 5 m		XYes 2□ No	Hospital: 1 Inpatie		Outpatient 3	LI DON					W AT SCENE				
Du de la	cation:	27. Manner of Death  1 Natural 5 Pending investigatio	28a. Date of Inju (Month, Da n /2//8/9	143	b. Time of Injury	28c. Inju	ury at ork? ]Yes 2,⊠No		now Injury occur		Cent				
DIVIS	6 =	3 Suicide 6 Could not be determined	266. Pace of in	c. (Specify)	starm, street, t	actory, office		28f. Location City or To	(Street and Num. wn, State) アイモル	ber or Rura	il Routa Number,				
To the Hospital within 24 hours To the Funeral C	Medical Cert	29a. Certifier (Check only one)	nysician: To the best miner: On the basis of and manner st	examination:	ige, death occi and/or investig	urred at the t gation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and m date and place,	anner as st	ated. the cause(s)				
To th	M M	29b. Signature and title of certifier	01			29c. Licen	se number		29d. Date signe	ed (Month,	Day, Year)				

DEC. 19, 1998 O.C.M.E

d cause of death (Newn 23m) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Marish 98 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Bay Care Center Camp. Me. Dorchester If Under 1 Year If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Feb. 13, 1913 9. Birthplece (Stete or Foreign Country) Virginia Sex 1 M 2 F **Funeral** Months Deys Hours Director 27-10-6519 Usuel Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location d other than "natural", or items 23s or 28s-f show event, the Medical Example; must be notified at 10d. Inside City Limits Director 1 Yes 2 No Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 520 Glenburn Ave. USA death 21613 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Rece - American Indian. Bleck, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: P 3 N Widowed 4 Divorced Black. Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondery (0-12) Collaga (1-4or 5+) Someone else's home Homemaker Unknown Pages 1 and 2 should be filed vent of Health end Mental Hygient: If Nem 27 Is marked other 18. Mother's Name (First, Middle, Melden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 Jenkins George Mary Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 a Department of Health er Important: if Nem 27 is any Injury or other trsu once. Eleanore Hankerson, sister Booth Street, Salisbury, Maryland 21801 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bethel Cemetery 12/28/98 Cambridge, Maryland 22. Name end Address of Feclity Bennie Smith 21. Signeture of Funerel Service Licensee Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immedieta Causa (Finel diseese or condition rasulting in deeth) /Medical Examiner Dua to (or as e consequence of): Examiner Ulcer The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest tran pue Due to (or es e consequence of): physician e renz Physician/Medical Due to (or es e consequence of) 83 ettending p the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ thknown by Completed 24b. Ware autopsy findings evalleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? page 2 has 1 Yes 2 No 1 Yes 20 10 certificate director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) Hospital or Attending Pi 124 hours after death.
 Funeral Director: After ti letely filled in by the funera Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier 🕍 Certifying Physician: To tha best of my knowledga, deeth occurred et tha time, date end plece, end dua to tha ceuse(s) end menner es steted. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

VINODRAI MEHTA 300 AURORA ST CAMBRIDGE, MD 21613 31. Dete filed (Month, Dey, Year)
DEC 2 8 1998 32. Registraris Signeture

30. Nema and eddress of person who completed causa of deeth (item 23e) (Type, Print)

attends

015541.

Baltimore, Maryland 21215-0020

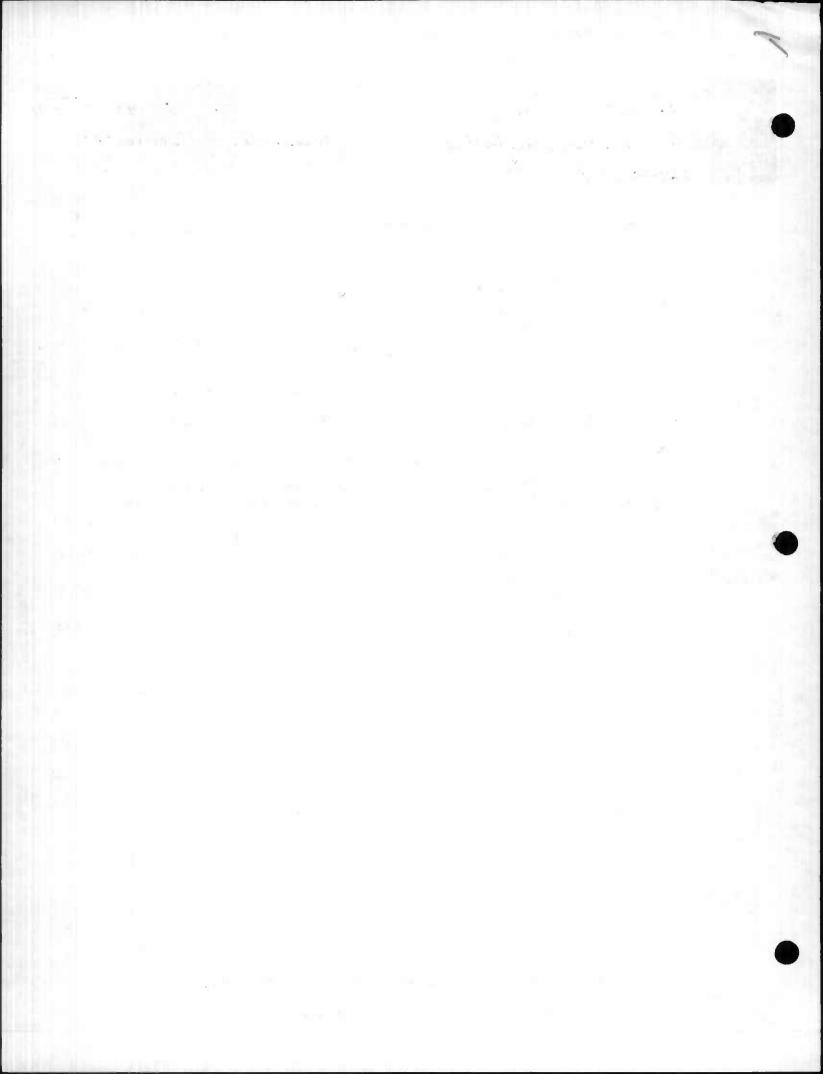
Box 68760.

P.O.

Records,

of Vital

Division



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Deeth Month Bowers GerdA MACIA 8 Am December 15 1998 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE Towson GBMC If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number Birthplaca (Stata or Foraign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 21 F Months Deys Yrs. MACYLAND 218-18-5184 June 19, 1924 Usual Residence of Decedent 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits 1 Yes 2 No Maryland ( Arroll Westminster 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Klee M.11 USA 1054 21157 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Dates: 14. Race - Amarican Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Meritel Status 1 ☐ Navar Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: white 3 ₩idowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) TEAMSters Union Secretary 0 1 7 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middle, Last) Alouis Gerer Helena Kertze 19b. Mailing Address (Street and Number or Rural Routa Number, Cify or Town, Stata, Zip Code, 19a. Informent's Neme/Reletionship (Type, Print) Cockeysville MD 10000 2 Old Providence WAY Bowers (Daughter 20b. Plece of Disposition (Name of cemetery, cramatory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Trinity Lutheran Cem 112/18/98 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Fecility re and Chapel, P.A. Pritts Funeral Hon 6 412 Washington Ped Westminster 21157 23a. Part / Inter the disease, or complications the proper tha death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, show, or heart fellure. List only one cause on each line. Approximate Intarval Between Onsat and Daath Immediate Cause (Final HEART 1) isease schemic diseese or condition resulting in deeth) Due to (or es e consequence of): pertension Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? Yss 2 No 3 Probably 4 Unknown mellitus betes 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HO Sprice 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 □ No investigetion 2 Accident 6 Could not be 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, and dua to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end mennar steted.

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/Medical

Examiner

Directo

Funeral

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Completed

**Funeral** 

Director

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the Maryland

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72 hours after

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injury or permit. Page Department of Important: If

**Physician** /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

edicai

29e. Certifier

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, 9SN signed by t 99 certificate funeral director, Aftar this Hospital or Attending efter death. Director: Aft To the Hospital or within 24 hours eff To the Funeral Di completely filled in

> State Registrar

·Ri 31. Dete filed (Month, Day, Year) DEC 3 0 1998

29b. Signatura and title of certifie

Gama 32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

6701

29c. Licansa number

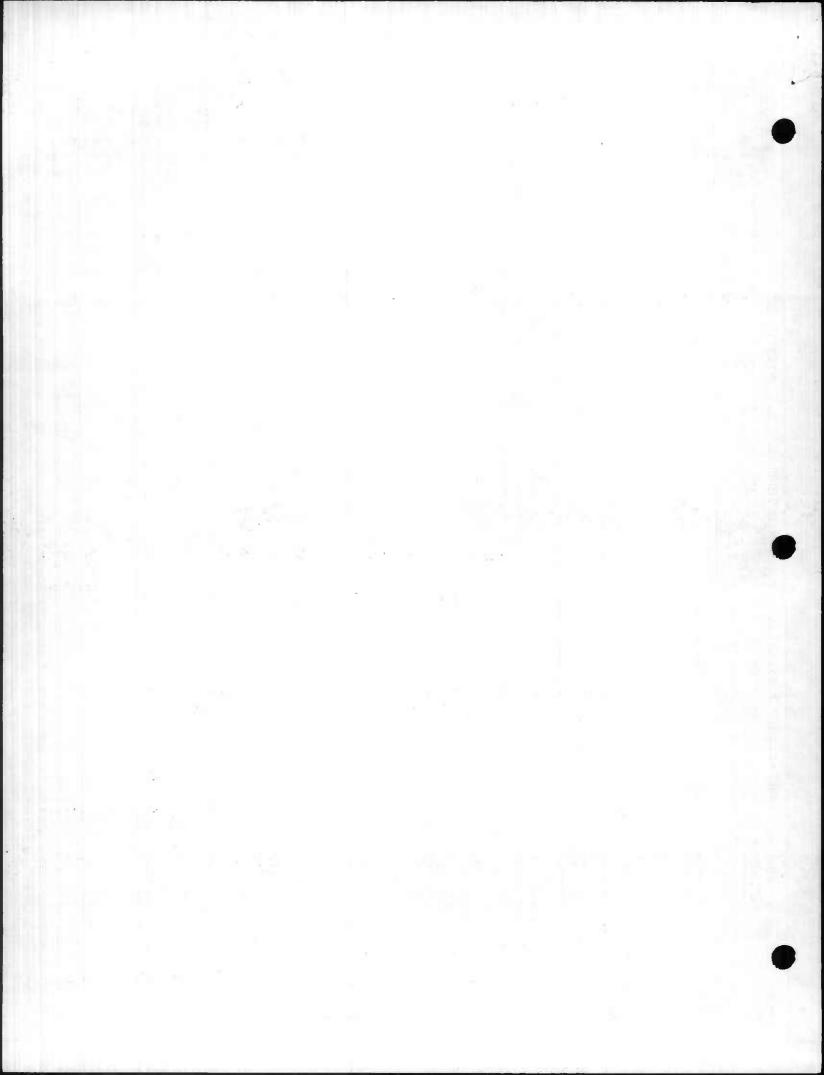
N. Charles St.

29d. Data signed (Month, Day, Year)

cember 21,1998

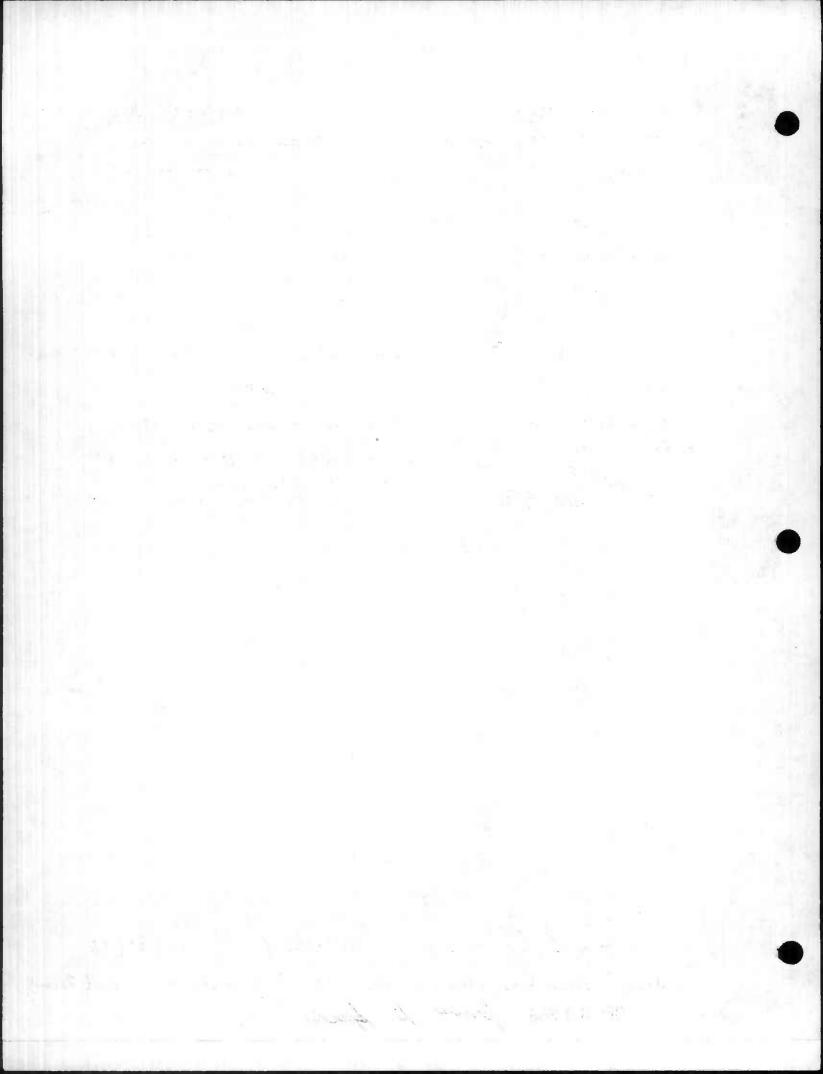
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State of Maryland / Department of Health and Mental Hygiene

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Mar a-fal	ctor	Maryland Ken	_			Wort	on			10					1 🗆 Yas 2💢
or 28	Director	10e. Street and Number						10f. Zip	Coda			10	0g. Cltizan of What Country?		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Veer Physician 7:05PM 27 1998 Virgin Dec Florence Bakewell /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Pines Easton Genesis ElderCare -If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Soctal Security Number 7. Age (In yrs. last birthday) Birthptaca (State or Foreign Country) **Funeral** Days 1 M 2 F 100 Yrs. Nov. 21,1898 Bethlehem, PA 175-12-9948 **Director** Usuat Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location the Marylen ns 23a or 28a-f ahor MD Talbot Easton Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 610 Dutchmans Lane 21601 U.S.A. Funeral r than "netural", or items the Medical Exemples has Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus 12. Was Decedent Ever In U.S. Armed Forces?

1 Yes 2 No
If Yas, Giva
Yeer or Dates: Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: þ 3℃Widowed 4 Divorced White Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Etementary/Secondary (0-12) Coltege (1-4or 5+) 8 Homemaker own home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fill ment of Health end Mental Hant: If item 27 ia marked oth jury or other traumatic even Rebecca Livingston James Virgin 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Retationship (Type, Print) 1200 S. Washington St., Apt 1402, Easton, MD 21601 Mildred G. Gasbarre/Daughter altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation
Center, L.L.C. Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/29/98Chester, MD permit. Page Department of Important: If any injury or 21. Si 1 e Funeral Se License 22. Name end Address of Facility Fellows, Helfenbein, & Newnam Funeral Home, P.A., 200 South Harrison Street, Easton, Md 21601

Part1. Enter the diseasa, or comptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximata Intervet Between Onset and Death Physician EHYDRATION /Medical Immediate Cause (Finat disease or condition Examiner Examiner ANEMIA physicien and s the buriel-trans Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): TENS10N P.O. Box 68760. Physician/Medicai 80 DEMENTIA 186 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown DRESS/ON Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 U Yes 2 € No after deeth.

Director: After this certifications 25. Was case referred to medical examiner? Be 26. Placa ath Check only ona Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. tnjury at Work? 28d. Describe how tnjury occurred 5 Pending Investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide filled in 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner On the basis of exer end manner stated, (Check only one) trivestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

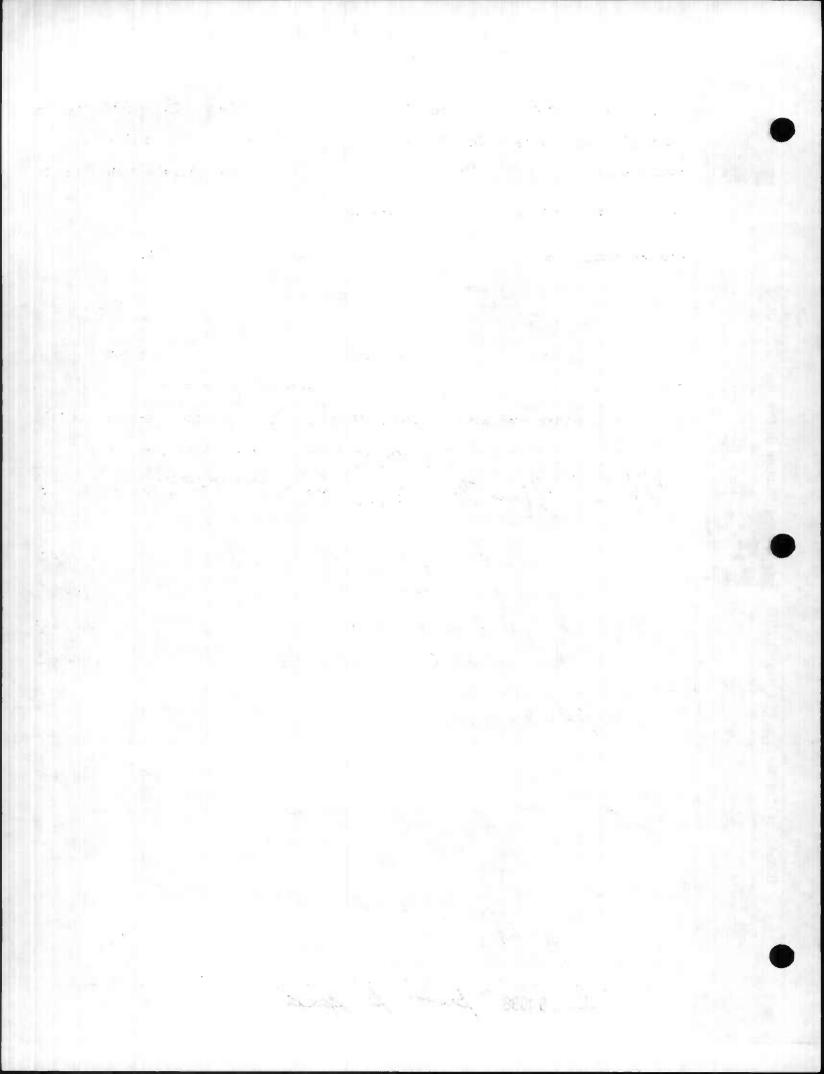
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508 IPYEWIYD AVE EASTON, MD 2/60/

State Registrar 29b. Signeture and title of certifier

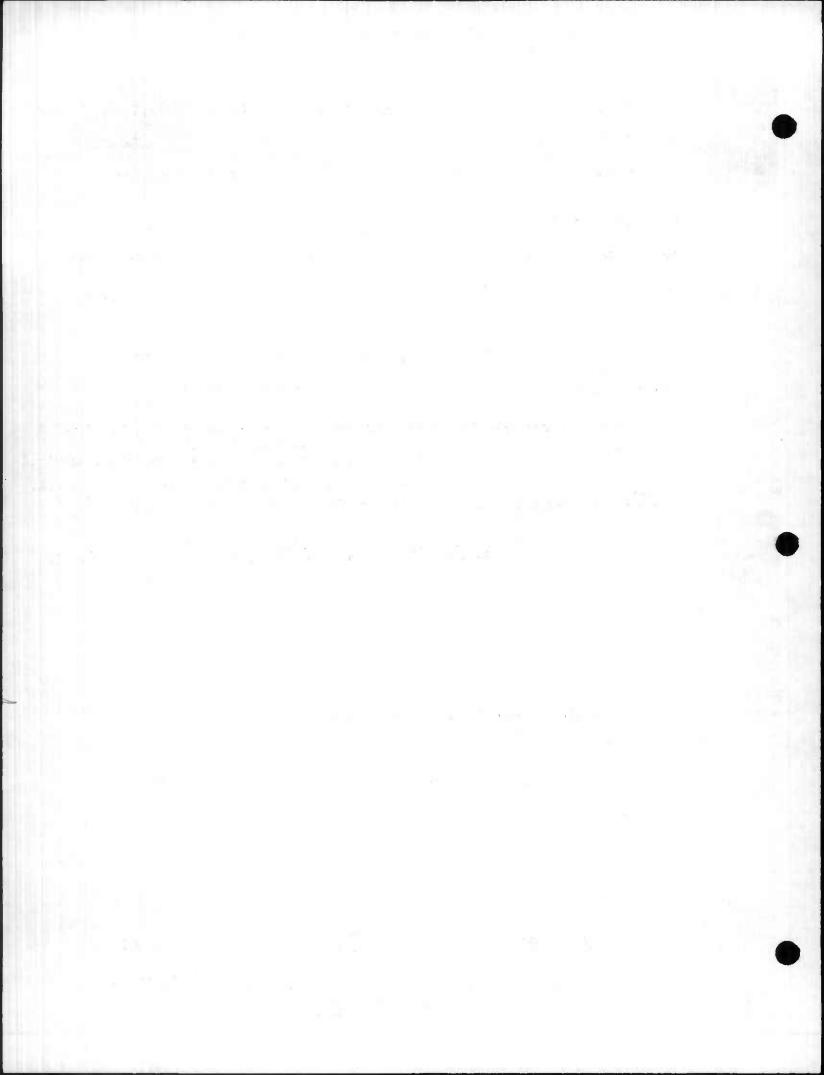
30. Nama and addrass of person who completed causa of daath (ttam 23a) (Type, Print) MAKAS

31. Date filed (Month, DEC) 2 9 19982. Ragistran Gianama



State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death	R	eg. No. 9 8	41:	265		
			1. Decedant's Name (First, Middla, La	st)	113118				2. Data of Deat	th		ime of Death		
	Physici /Medi		STANLEY JEROME			В	ENJAMI	N	Month DECEMBI	Day ER 28.	Yeer 1998 7	:54am		
	Examir		4e. Facility Name (If not institution, giv.	a street and number)				4b. City, Town, or		4c. County				
			WILLIAM HILL MAN	OR				EASTON			TALBOT			
	Funeral Director		111-09-0408	ex 7. Ag M 2□F	e (In yrs. last bi	rthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Dec. 6,	Year) 1909	9. Birthplace ( Country) New Yorl	Stata or Foreign		
	₽ug ≱_		Usual Rasidence of Dacedant  10a. Steta 10b. County		10c. City, Tow	m or Loca	ation				10d In	side City Limits		
	/anyle	5		a.h								Yes 2 No		
	the h	Director	Maryland Talb	OΓ		Ea	ston 10f. Zip Coda			On Ottono of 1	n of Whet Country?			
	With With	D	501 Dutchman's L	ane			Tot. Zip Cooa	501			ed State			
	Seath The 2	Funeral	11. Marital Status	12. Was Dacedant	Evar in U.S.	13. W	es Decedant of I		pecify Yes or No-		e - American inc			
21215-0020	filed within 72 hours after death with the Maryland hygiene. ther than "natural", or items 23a or 28a-f show int, its Medical Examiner must be notified at	by	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yes 2 ☑ If Yas, Giva Year or Datas:			Yas, specify Cube	anic Origin? (Sen, Mexican, Puerl	o Rican, atc.)		ck, Whita, atc.  White			
5-0	72 hc	Completed	15. Decedant's Ed (Specify only highast gra	lucation	16a	. Deceda	nt'e Usuel Occup	ation	tina	16b. Kind of Bi	usinass/Industry			
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pu	be filed half Hygie d other	Be	17. Father's Nama (First, Middla, Last)					18. Mothar's Nar	ne (First, Middla, I	Aaidan Suman	10)			
Maryland	Merke	2	Eugene Benjamin					Margai	et Lorsb	ach				
Mar	2 sho end ls me		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip (											
	1 and Health em 27		Gretchen Van Bou: 20a. Method of Disposition 1□ Burial 25 Cremation 3□	rgondien/S	Sister26	406	Arcadia	Shores	Circle,	Easton	_MD21	601		
altimore,	Pages 1 and of Heconst. If Item iry or other		20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐	Removal from State	20b. Place o cemete	ry, crama	tion (Nama of Itory or othar plac	Decembe	r 31, 19	20c Location -	City or Town, S	tata		
Ë	Pag ment ant: ury		4 ☐ Donation 5 ☐ Other (Specify		Chesap	eake	Cremati	ion Cente	r, LLC S	tevensy	evensville, Maryland			
Ball	permit. Page: Department of Important: If I eny Injury or once.		21. Signature of Funaral Sarvice Licen	CALL VENT OF	. 50	Fe1	Iows, He	ss of Fecility elfenbeir	& Newna	ewnam Funeral Home, P.A. Easton, Maryland 21601				
	_		23a. Part1. Entar tha disaasa, or com shock, or heart failura. List only	Appr	oximate									
	Physician /Medical Examiner		Immediate Causa (Final disaesa or condition rasulting in death)					Acciz				at and Death		
		-	Total III Security		Dua to (or as e	a to (or as a consequence of):								
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60,	icate be executed physician and s the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c	Due to (or as a									
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S, D	es that the de igned by the a be detached t	by Pi	HTRIAL				CILLATI	01	1 U Y	8 2⊠No	3 Probably	4 Unknown		
Records,	aw require is been sig 2 should t	Completed t	SEIZURE	Dison	RDEK				24a. Was a perform		24b. Ware eu evallable completi of daeth'	prior to on of causa		
	0 - 0	E	URINARY	TALCON	TINEN				1 □ Y8	s 2 No	1 ☐ Yes	2□ No		
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10	g Physer this	n: T	27. Mennar of Death	28a. Deta of Inju (Month, Day		Tima of	28c. Injury Work	y at	28d. Dascribe ho					
0	Attending For death.	atio	1. □Natural 5 □ Panding 2 □ Accidant Investigation		y rear)	injury		Yes 2 □ No						
Division	al or Attendi s after death al Director: A ed in by the f	Certification:	3 Suicida 6 Could not be determined	28a. Piace of Injubuilding, etc	ury - At homa, fa c. (Specify)	arm, straa	t, factory, office		28f. Location (St. City or Town		er or Rural Rout	e Number,		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edicai	29a. Cartifier (Check only one)  Cartifying Physics  Cartifying Ph	reician: To the bast of iner: On the basis of and menner sta	axamination an	daath o	ccurred et the tim stigation, in my o	ne, dete end place pinion, death occu	, and dua to tha ca rred at the tima, da	ausa(s) and ma ate and plece,	anner as stated. and due to the c	euse(s)		
	Withi To th	X	29b. Signeture end titla of certifier				29c. Licenso	e numbar			d (Month, Dey, )	(ear)		
			In Shaw	MD			026	350		12/28	198			
			30. Nema end address of person who	complated ceuse of de	eeth (Item 23e)	(Type, Pr				, ,				
			When 5 Bosnen	MD 80	n S. 7A	LBAT	-57 5	T. MICHA	IECS M	11) 2/1	13			
	Sta	te	31. Data filed (Month, Pay Year) 9	1999 <sup>32. Registre</sup>	ar's Signatura	1	9 1			7.0	()			



State of Maryland / Department of Health and Mental Hygiene 13 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Vee Ethel May Barr 4:25 AM Dec. 18 1998 /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel | Honder 1 Yeer | Honder 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Min. | March 8, 1 7. Age (In yrs. last birthdey) 5. Social Security Number Birthpiace (State or Foreign Country) **Funeral** 1□M 2\ F Months Yrs 176-20-3361 69 Director Usuel Residence of Decedent tha Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Nema 23a or 28a-f show Director 1 ☐ Yes 2 ☐ No Queen Anne's Stevensville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with P.O. Box #2, 107 Davidson Road U.S.A. Funeral 21666 12. Wes Decedent Ever in U,S Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Married 2 X Merried 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 8 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Pagas 1 and 2 should be f nent of Health and Mental I marked Benjamin Stipe Mabel Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Item 27 la P.O. Box #2, 107 Davidson Road, Stevensville, MD21666 William D. Barr Husband 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Dec. 18, 20c. Location - City or Town, Stete 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State = 8 Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Ctr. Stevensville, MD 21. Signeture/of Pune Service License 22. Name end Address of Fecility U Fellows, Helfenbein & Newnam Funeral Home P.A. 106 Shamrock Road, Chester, MD 21619 Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardlec or raspiratory arrest, shock, or heert feilure. List only one ceuse on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediete Causa (Final immacranial hemorrhage diseese or condition resulting in deeth) Examiner atherosceptotic Vascular disease Examiner 20 yrs The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disaese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): hyperlipidemia

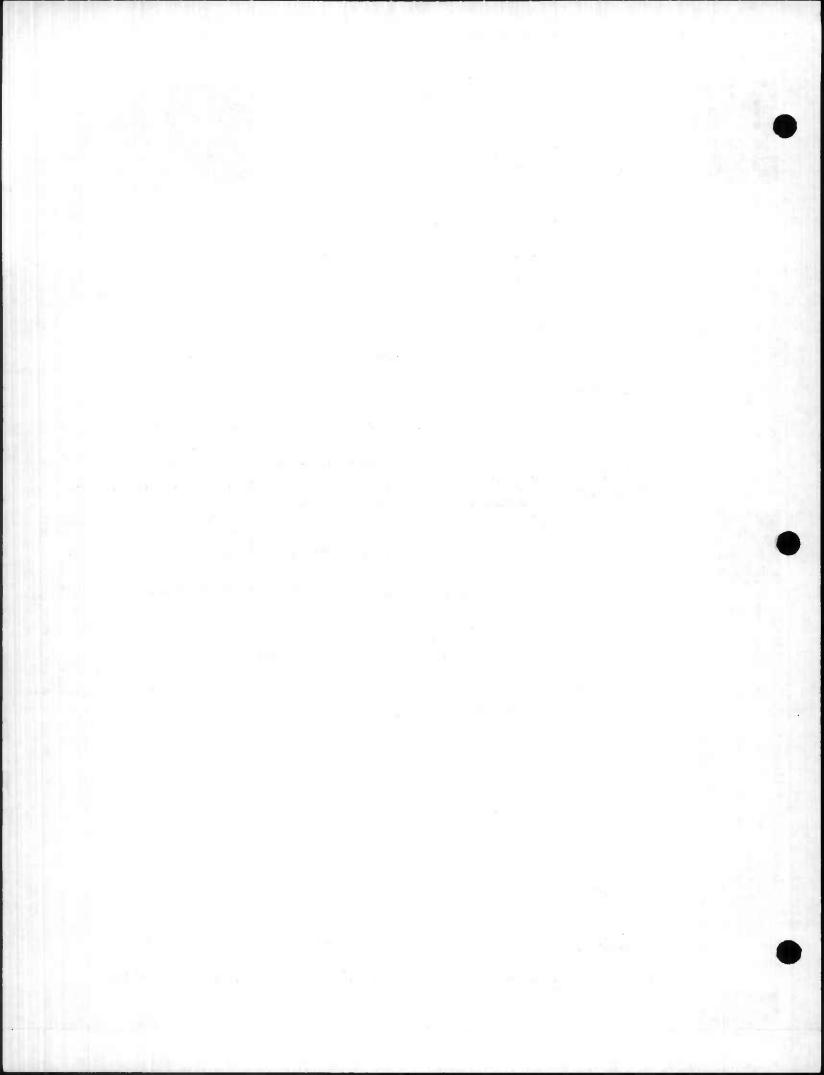
Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical diabetes mellitus type 2 USB 88 P.O. Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? congestive heart fulure 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, by ata has been signe paga 2 should be 24b. Were eutopsy findings evelleble prior to Completed 24e. Was an autopsy performed? completion of cause of death? cartificata 1 Yes 2 No 1 Yes 2 No of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Deeth | Check only one) Hospital: 1 Hipatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division Affer 5 Pending investigation 1 Maturel To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and plece, end due to the causa(s) end mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, deta end plece, and dua to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture end the of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 12-18-98 044161 30. Nama end eddrass of person who completed cause of death (Itam 23e) (Type, Print).
Puncia Czapp, mp 200 Trmum Parkway Annapolis Mp 21401 Huncia (Zapp, mo 31. Date filed (Month, Day, Year)
DEC 2 2 1998 32. Registrar's Signeture State

**DHMH 16 Rev 6/95** 

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 1, 1267

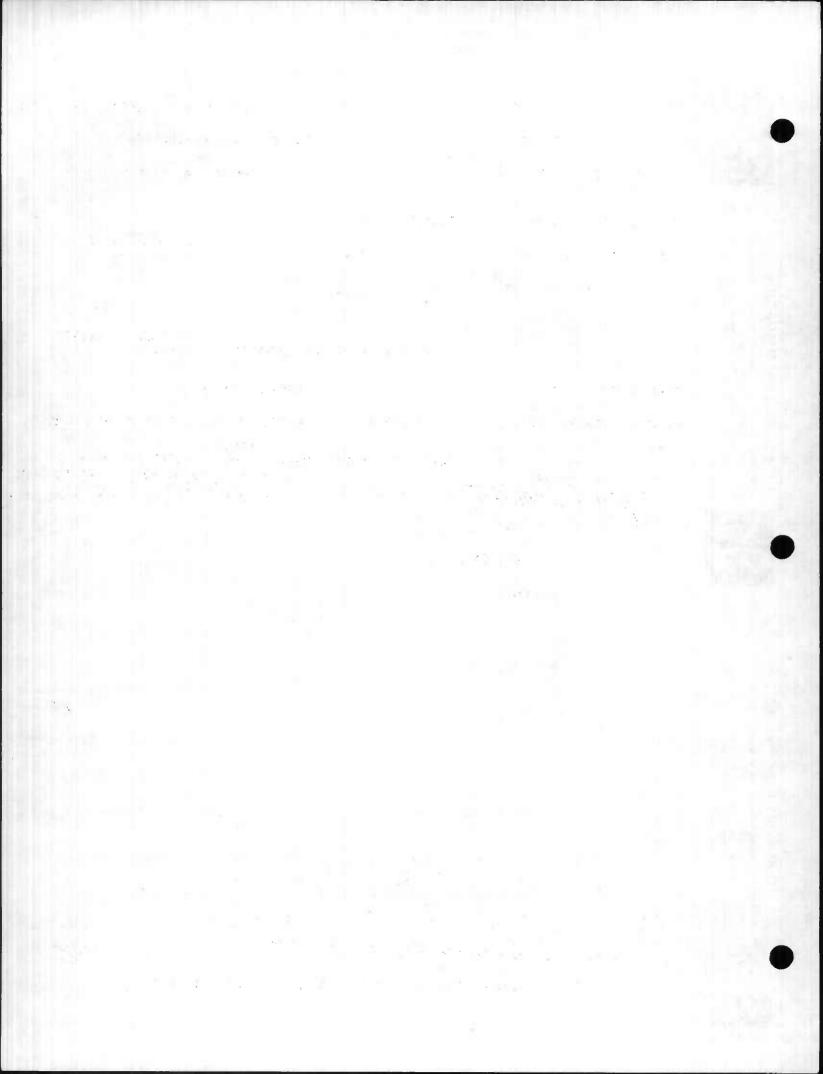
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	1. Decedent's Na	ame (First, Middle, La	st)						2. Date of Dea		Yaar	3. Tima of Death	
Physician /Medical	LOUIS S	HIRLEY CLA	PPER						DECEMBE		998	11:15 A.M	
Examiner	4a Facility Name	(If not institution, giv	a streat and numb	er)				4b. City, Town, or I	Location of Daath	4c. County	of Death		
	12636 B	ILLINGTON	ROAD					SILVER S	PRING	MONTG	OMERY		
Funeral Director	5. Social Sacurity 486-14-	0105	ex XXM 2□F	Age (In yrs	last birth	Months	er 1 Year Days		(Month, Da	, Year) 0, 1916	Cour		
h the Maryland r 28a-f show Inciting at	10a. State	10b. County		10c. C	ty, Town	or Location		10d. Inside Cli					
Mar	MARYLAN	D MONTGOME	RY	SI	LVER	SPRING	7			1 ☐ Yes			
vith the Mai or 28a-f s be notthed Director	10e. Street and I	Number				10f. Z	ip Code			10g. Citizen of V			
23a 23a		ILLINGTON	ROAD			20	904			UNITED OF AMER		2.5	
natural, or items 23a or 28a-f show draft Examiner must be nottled at each of by Funeral Director	3 Widowed	s arried <b>ZXX</b> Married d 4 Divorced	12. Was Deceda Armed Force 1 KM es 2 If Yes, Give Year or Data	ns? □ No 19	42-	13. Was Dec If Yes, sp	ecify Cub	Hispanic Origin? (S pan, Mexicen, Puert Specify:	pecify Yas or No o Ricen, atc.)	Specify	ck, White,		
netural;	100	15. Decedent's Ed			16a. D	ecedent's Us	ual Occu	pation during most of wor	tina	16b. Kind of B	usiness/in	dustry	
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C A	ODEN HE			-	ETTA SHI								
D E E	19a. tnformant's	Name/Ralationship (						t and Number or Ru					
565	GRACE A	. CLAPPER	(WIFE)					GTON ROAD	SILVER			LAND 20904	
2 2 0		Disposition 2 Cramation 3 Cn 5 Other (Specif		ate	cematary,	Disposition (N crematory of VN MEMO	other pla RIAI	PARK	DEC.24, 1998	20c. Location -	LE MA	ARYLAND	
Department of Important: If any Injury or once.	21. Six atur uneral Service Licensee  22. Name and Address of Facility HINES-RINALDI FUNET  11800 NEW HAMPSHIRI  SILVER SPRING MARYI  23a. Patt. Ent if the disease of complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode for heart failure. Ist only one cause on each line.											ENUE	
Medical Examiner pue pue pue pue pue pue pue pue pue pue	Imm data Caus disaasa or cond resulting In deat	ition h)	a. LUNG CA	Dua to (		onsequence o					1	Onsat and Death	
a axec	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.												
certificate be executed nding physician and use es the burial-transit n/Medical Examir	resulting in deat	ints	С.	Due to (	or as a co	nsequence of	):	9 1					
intend for us			d										
d by the setached		nificant conditions c	ontributing to deat	h but not ra	sulting in t	ha undarlying	causa g	iven in Part I.		tobacco use co Yes 2□No		o the cause of death? bably 4 Unknown	
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ate has page 2	130								10	res XXNo	1 (	☐Yes 2☐No	
certificate rector, pag	25. Was case re	ferred to medical						26. Place of De	ath (Check only o	ne)	1		
his cert il direct	examiner?		Hospital: 1 ☐ Inp	atient 2	] ER/Outr	atient 3 I	DOA O	ther: 4 Nursing h		dence 8 Oth	ner (Specia	(y)	
		27. Manner of Death  1 Inpatient 2 EH/Outpatient 3 DOA  28a. Date of Injury  (Month, Day Year)  28c. Injury  MA						ury at ork?	111111111111111111111111111111111111111	now Injury occur			
tal or Attending P is after death.  al Director: After t ed in by the funers  Certification:	3 ☐ Suicida 4 ☐ Homicid	6 Could not b	200. Placa of	Injury - At I , etc. (Spec	nome, farr	n, street, facto	ory, office	,	28f. Location (: City or Tou		ber or Run	al Routa Number,	
Funer (aly fill		Certifying Ph	ysician: To the be niner: On the basi and manner	s of examin	owledge, atlon and/	death occurre for investigation	d at tha ton, in my	tima, data and piace opinion, death occi	a, and due to tha urred at tha time,	cause(s) and made and place,	annar as s and due t	stated. o tha cause(s)	
To the comple		and title of certifier	Thu	lu	W	2	9c. Licer	18813		29d. Data signe	d (Month,	Day, Year)	
15	30 Name and a	drass of pareon who	completed cause	of death /lic	m 239) /T	ime Print)	0	, 0010			7	(70	

State Registrar

IRA TAUBER, M.D.,
31. Date filed (Month, Day, Year)
DEC 2 9 19

GEORGIA

AVENUE SILVER SPRING MARYLAND 20902



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth **Physician** Sylvia Colbreuner 1998 7:00 PM Dec 27 /Medical 4b. City, Town, or Location of Death 4a Fecility Nema (If not institution, give street end number) 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 7. Age (In yrs. last birthdey) H Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, O.F. Yrs. Months Deys Hours Min. Jan. 24 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** 1913 1□M 2√F 057-01-5177 Brooklyn, Director Usual Rasidanca of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits 7 is marked other than "naturst", or itsms 23s or 28s-f show trsumstic svant, the Medical Exerciser must be notified at iX Nes 2 □ No Montgomery Director MD Rockville 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 20852 6121 Montrose Road Funeral 72 hours after death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Giva Year or Datas: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yas 2 No Specify: Maryland 21215-0020 Specify: White p 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education rada completed) Collega (1-4or 5+) Elamantary/Secondary (0-12) Hygiene. Legal Secretary DC Juvenile Court 18. Mother's Nama (First, Middle, Meidan Sumeme) 17. Fathar's Nama (First, Middle, Last) should be fund Mental h Herman Friedman h and Mental Hermina Klein 19a. informent's Name/Relationship (Type, Print)
Myron Colbreuner/Son 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda, permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any injury or other traum 5225 Connecticut Ave. Washington, DC 20015 Baltimore, 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 12/29/98 Olney, MD Judean Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura Ineral Service Licansee 22. Nama and Addrass of Facility Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, DC 22201 Part 1. Error the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, be heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final CEREBROVASCULAR ACCIDENT diseasa or condition Examiner Examiner ARTERIOSCLEROSIS EREBRAL sician and burial-transit that the death certificate be executed Sequentially list conditions, if eny, laeding to immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequenca of) physician a Box 68760. Physician/Medicai Dua to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown CARDIOMYOPATHY Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? SPIRATION PNECIMONITIS Completed 24e. Was an autopsy law. page 2 has this certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: director. Be 25. Was casa rafarred to medical axaminar? 26. Placa of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28d. Dascribe how injury occurred 28c. tnjury at Work? 28a. Data of tnjury (Month, Day Year) 28b. Tima of 1 Natural 5 Panding

Division of Vital funeral After or Attending To the Hospital or Attandin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death.

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STEVEN 31. Dete filed (Month, Day, Year)

29b. Signature and title of cartifian

2 Accidant

3 Suicide

4 Homicide

29a. Cartifier

invastigation

6 Could not be datamined

LIPSON 32. Registrar's Signetura

son

30. Nama and addrass of person who complated causa of death (Itam, 23a) (Type, Print)

MONTROSE KD, ROCKVILLE 6121

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

1 ☐ Yas 2 ☐ No

D 05885

1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licanse numbar

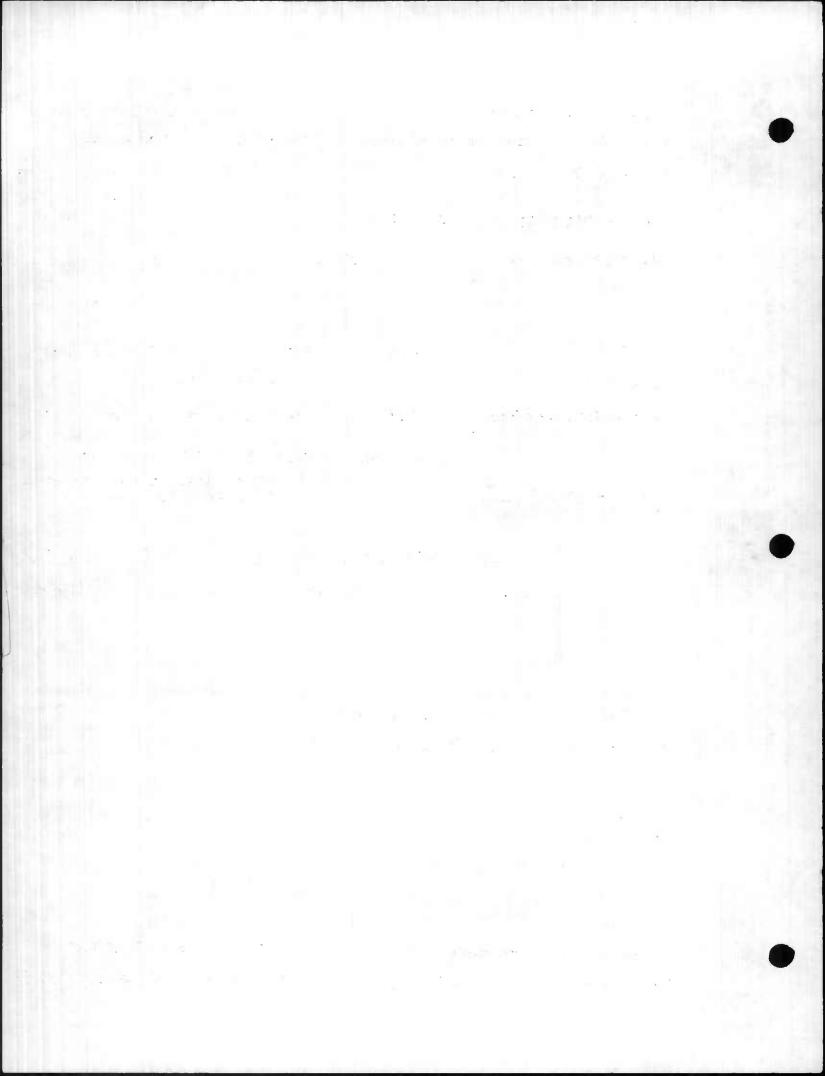
State Registrar

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DEC 30

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

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#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day CimoKowski Edwin December 28, 9:50AM 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Regional Laurel aurel Hospital George's If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiace (Stata or Foreign Country) 1⊠M 2□F 83 577-38-8084 Feb. 8,1915 Pennsylvania Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6604 Ian Street U.S.A. 14. Race - Amarican Indian, Black, White, etc. 20784 12. Was Dacedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces : 1 ⊠ Yes 2 □ No If Yes, Give Yaar or Datas: WWII 1 Nevar Married 2 Married Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Spacify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Law 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Frank Cimokowski Pelczarska Josephine 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance D. Cornelsen 8403 Snowden Loop Court Laurel, Maryland 20708 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/31/98 Silver Spring, Maryland 21. Signature of Funarai Service Licenses 22. Nama and Address of Facility Francis J. Collins Funeral Home, Inc. Com 500 University Blvd., W., Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death Immadlate Cause (Final disaase or condition resulting in death) 5 days ere bro vascular Sequentially list conditions, it any, leading to immediate causa. Enter Undarlying Cause (Diseasa or injury thet initiated events resulting in deeth) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 ₹No 3 Probably 4 Unknown Prostate 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No

**Physician** /Medical Examiner

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signed by

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this funeral

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

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permit. Pages 1 and 2 st Department of Health enc Important: If Item 27 Ia m any injury or other traun

**Physician** 

/Medical

Examiner

Director

Funeral

q

Completed

Be 20

**Funeral** 

**Director** 

?? Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examiner must be notified at

2 should be filed within 72 hours after nend Mental Hygiene.
Is marked other than "natural", or its

3altimore, Maryland 21215-0020

Box 68760. certificate be

Records, P.O.

Division of Vital

with the Maryland

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Examiner Physician/Medical by Completed Be

attending physician and for use as the buriel-transit 2 Certification:

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical examiner? 1 Yes 2 LNO

27. Manner of Death

29a. Certifie (Check only one)

1 (1) Naturel 5 Pending 2 Accident 3 Suicida 4 Homicide

6 Could not be determined

rehal / de

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28a. Date of tnjury (Month, Day Year) 28e. Pleca of tnjury - At home, farm, atreet, factory, office building, etc. (Specify)

1 Impatient 2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 1 Yes 2 No

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State) 1 Certifying Phyatcian: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as steted.

COLLEGE PARK MD 20740

28d. Dascribe how injury occurred

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29b. Signature and title of cartifier

29c. License number D 26287 29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

M BERAND 31. Date filed (Month, Day, Year)

7305 BALTIMORE 32. Registrar's Signatura

rand, un

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State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 29, 1998 **Physician** ARTHUR L. COOK 9:32 AM /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Hunder 24 Hrs. 8. Date of Birth Hours Min. May 20, 1922 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Davs 1 M 2 TF Virginia 223-20-8369本 76 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Nams 23a or 28a-f show any Injury or other traumatic event, the Markel Examinar must be notified as 1 No 2 No Director Potomac Md Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7701 Scotland Drive 20854 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 20 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry, Stone Co Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 5th Grade College (1-4or 5+) Mechanic Rockville Crush 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelson Cook Frances Parham 19a. Informant's Name/Relationship (Type, Print Wife) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7701 Scotland Drive, Potomac, Md 20854 Ellavee P. Cook 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete PC Surial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Cem. 1/2/99 Silver Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) 2 Sign Ture of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md 23a. Pert f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only sine cause on each line. Approximate Intervel Between Onset and Death **Physician** Ventricular fibrillation /Medical Immediate Causa (Finel 5econd5 diseese or condition resulting in death) Examiner failure years Congestive heart Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or as a consequence of) years valvular heart disease Physician/Medical Due to (or as a consequence of): years artery Coronary disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown hyperten sion Division of Vitai Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat axaminer?

1 Ves 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homleide 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) To the To the F

State Registrar 29b. Signeture and title of certifies

31. Date filed (Month, Day, Year)

wylnul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy Fried, MD: Kalser Office, Holy Cross Hospital.

32. Registrar's Signature

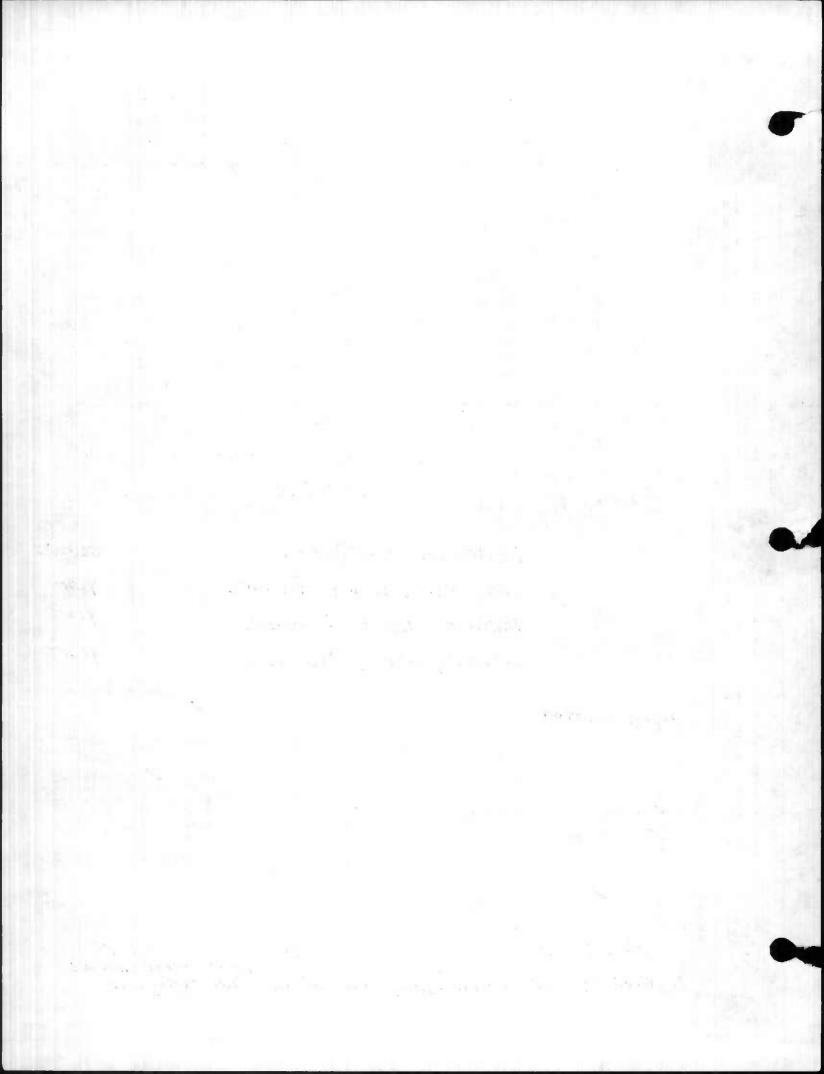
29c. License number

29d. Dete signed (Month, Day, Year)

12-29-98

1500 Forest Glen Rd

Silver Spring. MD



#### Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Charles C Cook 10:40am Dec 22,1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery er If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Ye 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 1⊠M 2□ F 026-12-4254 78 APRIL 20,1920 MASS. Usual Residence of Decedent 10d, Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location 1 Yes 2 No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2015 HARLEQUIN TERR. 20904 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Stetus Biack, Whita, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 FILE CLERK V.A. ADMINISTRATION 18. Mother's Nema (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GUY C. COOK HARRIET YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALTA L.A. COOK/ WIFE ITEM #10 SAME AS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 12/30/98 SILVER SPRING, MD. 21. Signature of Funeral Service Licersee 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. enter the mode of dying, such as cardiec or respiratory arrest -M00091 Wells 23a. Pert1. Enter the disease, or complication. If a caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death tmmedlete Cause (Finel diseese or condition resulting in deeth) perheenia 48-le Due to (or as a consequence of) Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2⊡-No 1 Dimpatient 2 ER/Outpatient 3□ DOA 28a. Dete of trijury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Maturel

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

rs 23a or 28a-f show

Nems 2

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other

는 6 permit. Pege Department of Important: If any Injury or

the Medical Examiner

Director

Funeral

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Completed

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Peges 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiene.

Baitimore, Maryland 21215-0020

Box 68760.

P.O.

/Medical

hysician and the burish-transit 65 080 page 2

Examiner physician Physician/Medicai signed by the a d be detached f Completed After this

by

2 Accident

4 Homicide

29b. Signeture end title of certifig

3 Suicide

29a. Certifier (Check only one)

The law requires that the death certificate be executed Records, of Vital Physician: Medical Certification: To Be Division or Attanding s after death. the in by

Hospital 24 hours

To the To the F

State Registrar

Valle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ROSENBAUM M.D. 31. Date filed (Month, Day, Year)

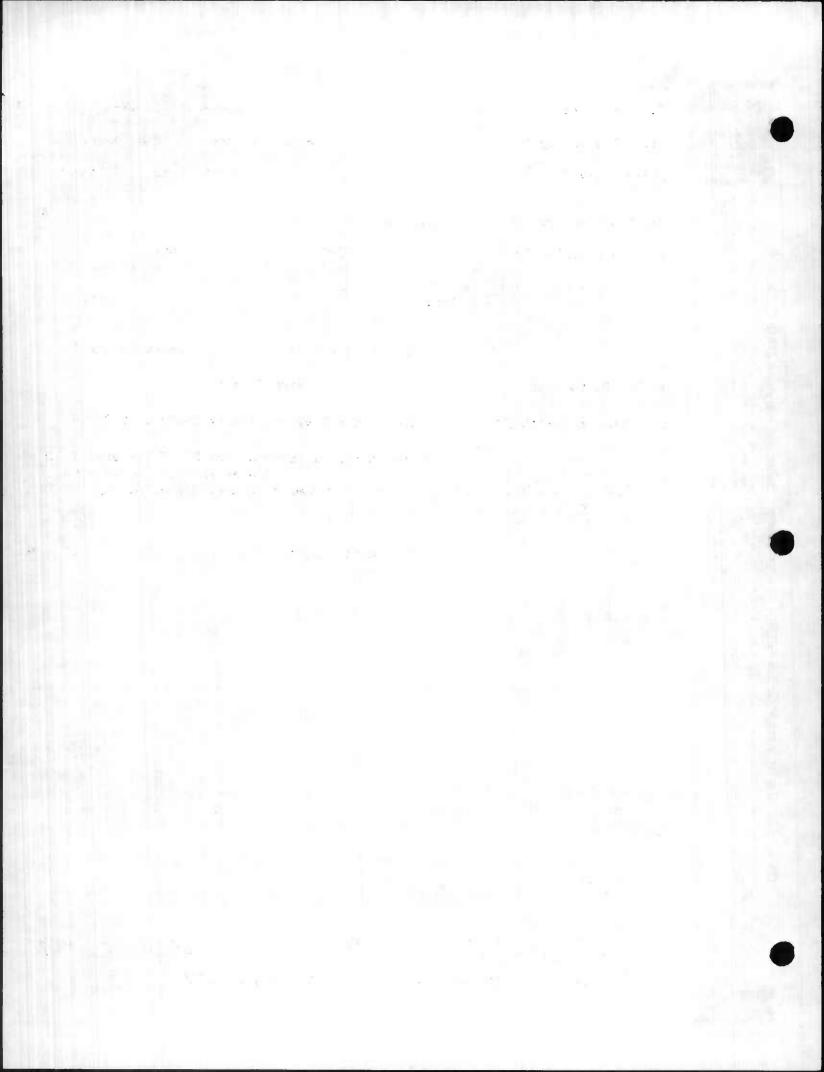
3720 Farragut Ave Kensington Md 20895

32. Registrar's Signature **DEC 28** Dener

TREATY TO THE ENGLY. and the state of 

State of Maryland / Department of Health and Mental Hygiene

James R. Coziahr  James R. Coziahr  4a Facility Nama (If not institution, give street and number)  2228 Blue Valley Dr  Silver Spring  Montgomery  5. Sociel Security Number  6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month, Day, Year)  Months Days Hours Min. (Month, Day, Year)  Month, Day, Year)  9. Birthplaca (Stete or Fore Country)		1. Decedent's Nama (First, Middle, L	ast)				2. Dete of Dea		3. Time of D		
4.5 Solid Search Plane (Prior Institution) per attention of per attention	Physician	James R. Cozial	r				Decembe				
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\$ 5.0 cold Security Humber    Cold	LAMIMICI	2228 Blue Valle	v Dr			Silver S	bring	Monte	omerv		
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100. Clarky   100. Clarky	Director		1 <b>X</b> M 2□ F	56 Yr	s. Months Days	Hours Min.	Mar 8,	1942			
Elementary  Secondary (0-12)   College (1-4c-5-5)   Airline Employee   American Airlines	filed within 72 hours efter death with the Maryland Hygiene. Hygiene. Inter then "natural", or items 23s or 28s-f show ant, the Medical Examinat must be notified at any the Medical Examinat must be notified at any or more any file of the contract of the		1	Oc. City, Town o	or Location			110			
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Elementary  Secondary (0-12)   College (1-4c-5-5)   Airline Employee   American Airlines	E	11. Maritei Stetus	Armed Forces?	ar in U,S.	<ol> <li>Was Decedent of H If Yas, specify Cub</li> </ol>	Hispanic Origin? (Span, Maxican, Puart	pecify Yas or No- p Ricen, atc.)				
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Elementary  Secondary (0-12)   College (1-4c-5-5)   Airline Employee   American Airlines	ed Hite	15. Decedent's I	The rest sales	16a D	ecedent's Usual Occur	pation		16b. Kind of Busin	ass/Industry		
17. Fether's Name (Prost, Modified, Leath   19. Modified   19. M	ole die	(Specify only highest g	rade completed)	((	Give kind of work done ife. DO NOT use retire	during most of world)	king				
17. Fether's Name (Prost, Modified, Leath   19. Modified   19. M	the the	Elementery/Secondary (0-12)	Collega (1-4or 5+)					American	Airlines		
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24a. Was an autopsy finding valiable prior to completion of cause of death?  25. Was casa referred to medical axaminar?  26. Placa of Death (Check only one)  27. Mennar of Death  1	0.0										
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20   Accident   3   Suicide   4   Homicida   1   Yes   2   No   28e. Plece of Injury - At homa, farm, straat, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, Stele)   29a. Cartifier   Check only one)   29a. Cartifier   Check only one)   29b. Signetura end titla of certifier   29b. Signetura end titla of certifier   29c. Licanse number   29d. Deta aigned (Month, Day, Year)   30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print)   31. Data filled (Month, Day, Year)   32. Registrar's Signatura   33. Rata filled (Month, Day, Year)   34. Registrar's Signatura   35. Rata filled (Month, Day, Year)   36. Rata filled (Month, Day, Year)   37. Rata filled (Month, Day, Year)   38. Registrar's Signatura   39. Rata filled (Month, Day, Year)   39. Rata fill			28a. Data of Injury	28b. Tin	na of 28c. Inju	ry at	28d. Dascribe h	ow injury occurred			
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Jill Gilbert 6112 Bellinham , #531, Baltimore, MD 21210		30 Name and address of passes with	0003001/December 26, 1998								
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AL POINT HALL PROVIDED LINE TO A CONTROL OF THE PROVIDENCE OF THE					, "JJI, Do	AT CIMOTE 9					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** Oscar B. Crist, Jr. December 24, 1998 9:50 AM /Medical 4b, City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not Institution, give street and number) Examiner 12513 Piedmont Road Clarksburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Hours 15 M 20 F Yrs. 71 231-24-6500 Virginia **Director** March 15, 1927 Usual Residence of Dacedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. Stete 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Clarksburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12513 Piedmont Road 20871 Funeral United States death 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Status filed within 72 hours after 1 XYes 2 No World If Yes, Give World Yeer or Detes: War II 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Salesman Paint Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event pages. 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 8 Oscar B. Crist, Sr. Augusta Parker 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12513 Piedmont Road, Clarksburg, Maryland 20871
ca of Disposition (Name of Dete 20c. Location - City or Town, State David Lee Crist/ Son 20b. Place of Disposition (Name of cametery, cremetory or other place) December 27, 1998 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 Donetion 5 Dother (Specify) Stonewall Jackson Memorial Cemetery Jackson Memorial Cemetery Lexington, Virginia
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, M00689 Rockville, Maryland 20850-2805 Le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest an failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediate Cause (Final /Medical DAT GULBECINOMA OF THE RIGHT LUNG MONTHU disease or condition resulting in deeth) Examiner Dua to (or as a consequanca ot): Examiner physician and is the bunal-transi Sequentielly list conditions, if any, laeding to immediate cause. Entar Underlying Ceuse (Diseese or Injury that initieted evants resulting in death) Lest Due to (or es e consaguence ot): The law requires that the death certificata be axed Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 88 esn signed by the a 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to should I 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate has b irector, page 2 si TE Yes 2X) No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 3□ DOA After this funaral 28a, Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 5 Pending Investigation 1 Netural after death. 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Pleca ot Injury - At homa, tarm, street, factory, office building, atc. (Specify) filled in by 4 Homicida 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

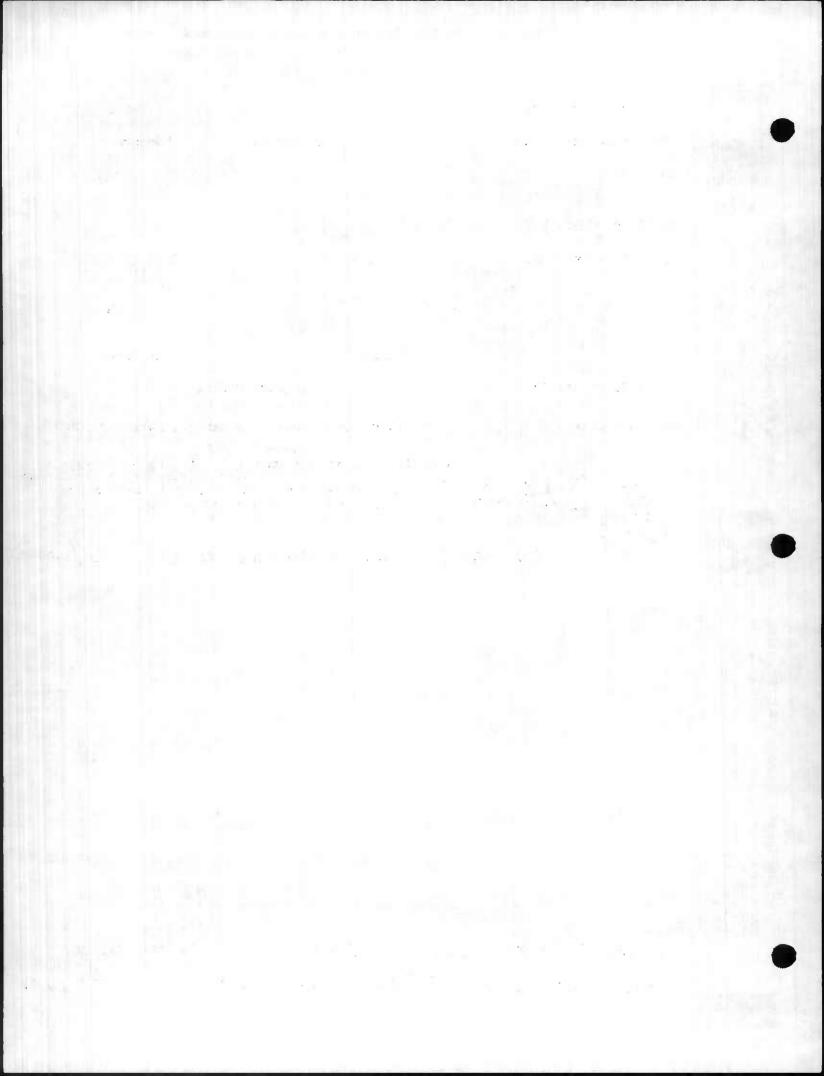
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 26, 1998 0+ of deeth (Itam 23a) (Type, Print)

32. Registrer's Signeture

State Registrar

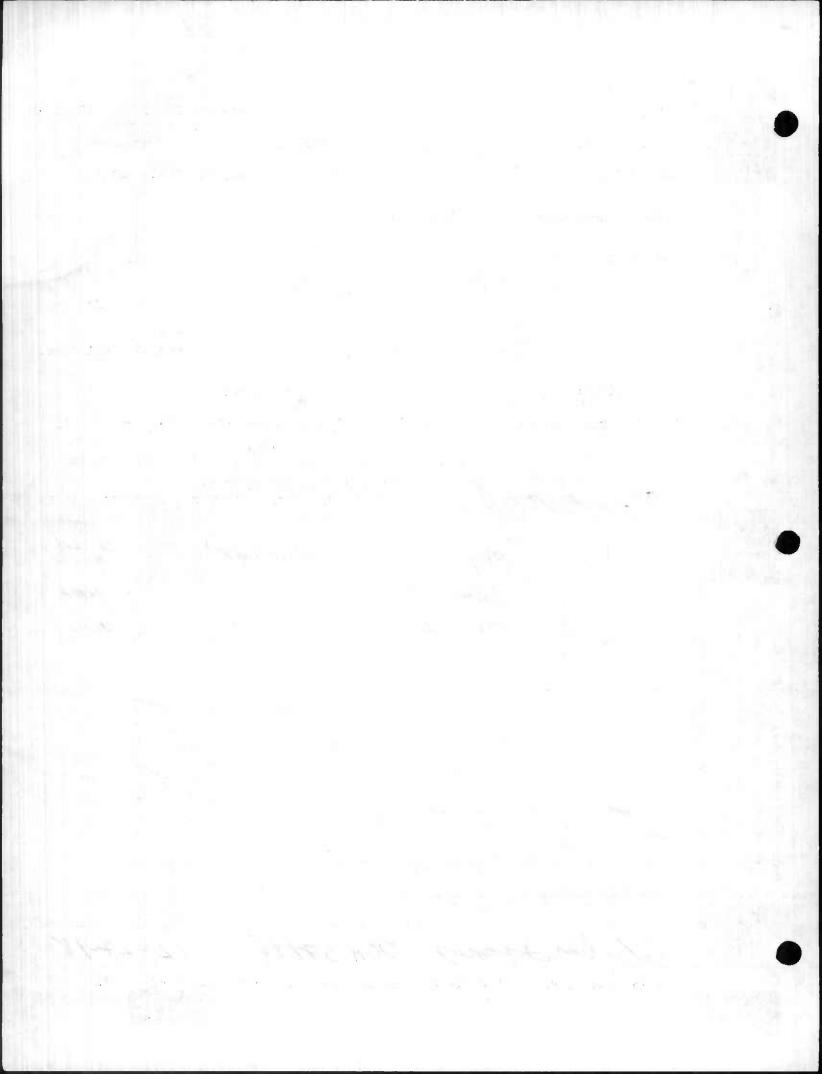
31. Dete tiled (Month, Day, Year)

**DEC 28** 



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Aug. 29, 1934 Be  10g. Citizen of What C  U.S.A.  Origin? (Specify Yes or No- an, Puerto Rican, etc.)  14. Rece - Am Bleck, Wh	11:11 A sth  mery inthplace (State or For Country) 1gium  10d. Inside City Lin  1xt Yes 2						
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Date 20c. Location - City of							
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AreTion	MIANTEZ						
	. 10						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
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#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Culver 1250 Gloria 1998 26 Dec 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva streat and number) 4c. County of Death montgomery Omex MonJzomery General If Under 24 Hrs. 8. Date of Birth Hours Min. May 13 1954 9. Birthplaca (Stata of Foreign Country) If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days 1 □ M 2 M F 44 215-62-6601 Yrs. Maryland Usual Rasidance of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits Spring Maryland Montgomery Silver 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905 United States 913 Ednor Road 12. Was Decedent Evar in U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married White 1 ☐ Yas 2 No Specify: 3 Widowad 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elamantary/Secondary (0-12) Librarian Assistant County Library 18. Mothar's Nema (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Ruth Minnick Alfred Peter Bayne 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 913 Ednor Road, Silver Spring, Maryland 20905 Kenneth Wayne Culver/Husband 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Parklawn Cemetery 12/30/98 Rockville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensee Muriel H. Barber Funeral Home 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, App. 20882 Approximata Intarval Batween Onset and Death Immediata Causa (Final disaasa or condition resulting in daath) arr Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that Initiated evants resulting In death) Last pramine Due to (or as a consaquanca of): 23b. Did tobacco uas contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner the death certificata be executed

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

**Funeral** 

**Director** 

Item 27 is marked other than "natural", or items 23s or other traumstic event, the Mod call Examiner myst be r

permit. Pagas 1 and 2 should be filed within 72 hours aftar 1 Department of Haalth and Mental Hyglene. Important: if Item 27 is marked other than "naturel, or itel any injury or other traumatic event, the Medical Exampted

Baltimore, Maryland 21215-0020

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Examiner physician and s tha burial-transit Physician/Medical 88 usa signed t P Completed or Attending Physician: Be

P.O. Box 68760,

Division of Vital Records,

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9 Certification: aftar daati Director:

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Wes case referred to medical exeminer? 1 Yas 2 No 27. Mannar of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 X Suicida 4 ☐ Homicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only

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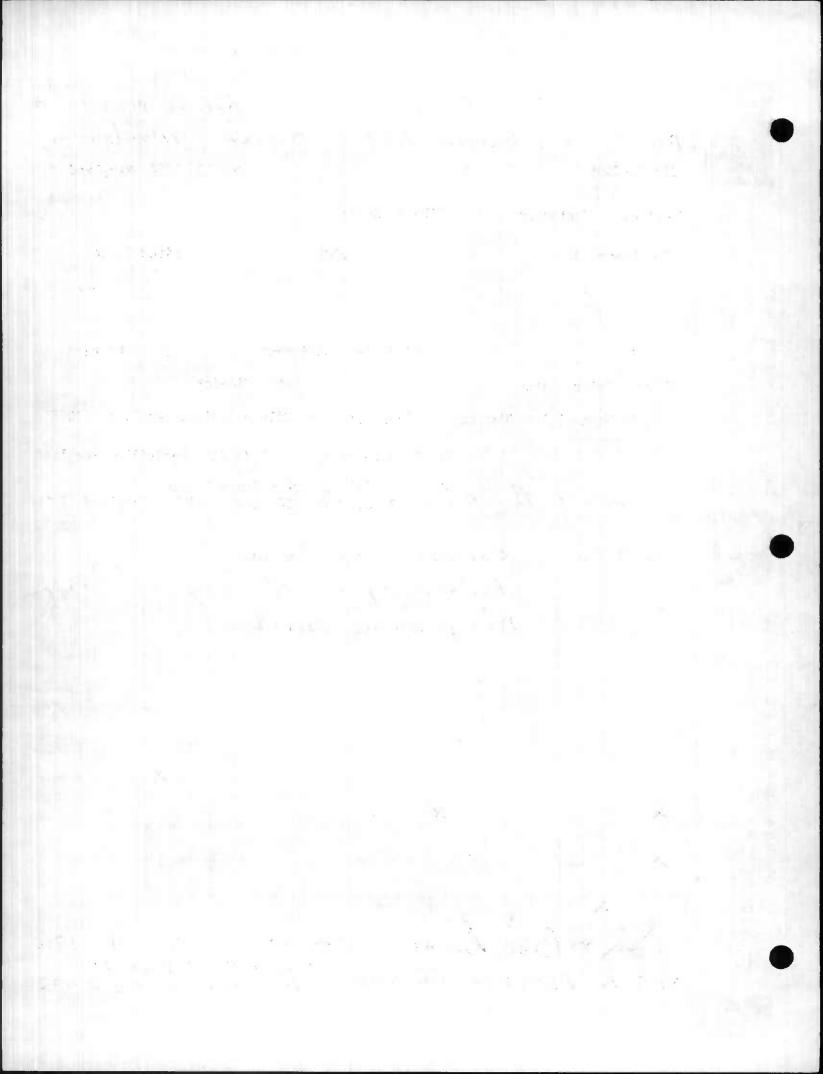
29d. Data signed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23e) (Type, Print) BRECHER, mo DME

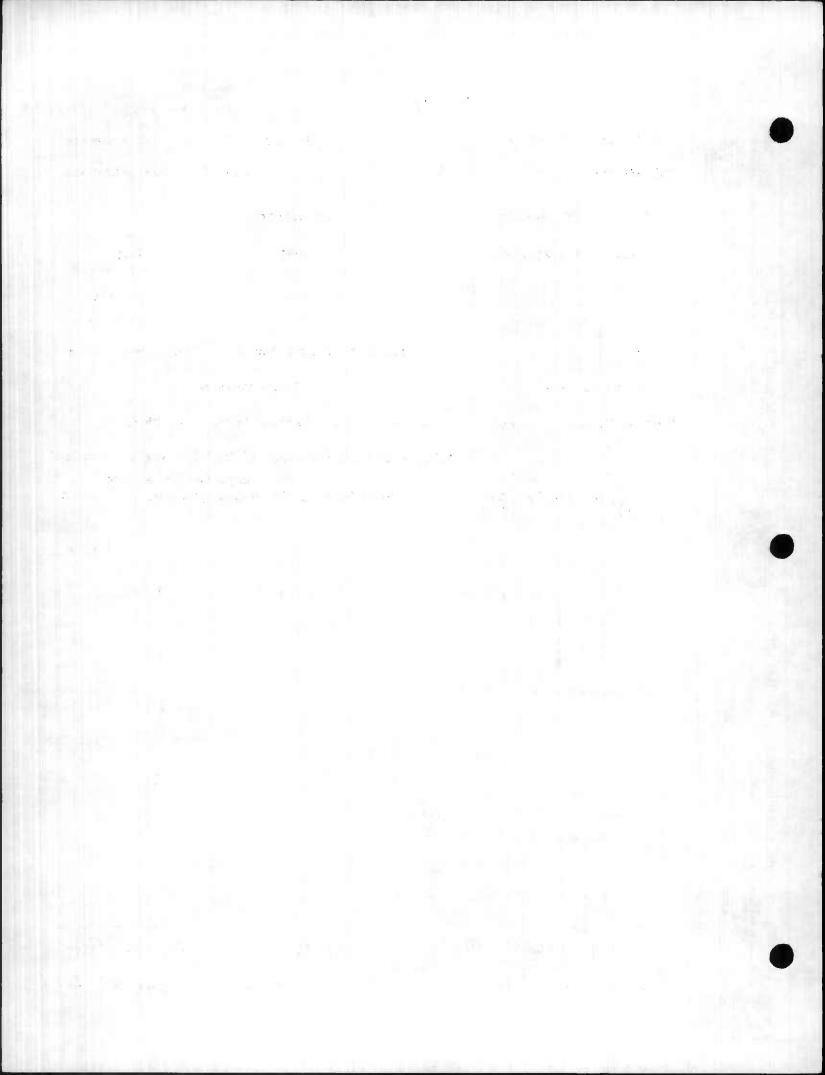
2101 metical Park Dr Silver Spring md

31. Data filed (Month, Day, Year) **DEC 29** 

32. Registrar's Signature



		Department Alice of the	ent Affalat- 1 -							Death		Mental Hyg	Reg. No.	1-6	127-	of Death
Physician /Medical		. Decedent'a Name (Fi		Jos		Cupp						Month Dec	22 19	Yaar 48	01:	24 A M
Examiner	ľ	a Facility Nama (If not Holy Cro			m <i>ber)</i>				4			ocation of Death		y of Death		
Funeral Director	85	5. Social Security Numb	er 6. S	•	7. Aga (In yr.		hday) (rs.	If Under 1 Months	Yaar Days	If Undar		-	1	9. Birth		te or Foreign
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ed within 72 hours ygiene. Then "naturel", It, Ir Woles Completed by			Decedent's E	ducation ade completed)		16a.	ia. Decedent's Usual Occupation (Giva kind of work done during most of wor life. DO NOT use retired)			16b. Kind of Busine			ness/Industry			
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De vertical de la contraction		7. Father's Name (First										na (First, Middle,			Juzo	
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within within To the comp		9b. Signatura and titla	of certifier		44.10					e number		29d. Data signed (Month, Day, Year)				-
6	30. Nama and addrass of person who completed cause of death (item 23a) (Typa, Print)  MARCALET T. SNOW MD 90/3 Flower Ave SI  31. Data (fled (March Day York))  32. Data (fled (March Day York))  33. Data (fled (March Day York))								Dec 2	12 1	1998					
	3	MARCA	of person who	-		em 23a) (	Typa, Pr	rint) 9013	FI	ower	A	ve Slu	n Sprin	g MO	20	901
State	3	31. Date filed (Month, D		32. F	egistrar's Sig		4	los	20 1/2	1						



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Deeth NILLIAM UMBERLAND, II DE CEMBER 21 4a. Fecility Nema (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Shady Grove Adventist Hospital Rockville Montgomery 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number if Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) Jan 22, 1928 9. Birthpiece (Stete or Foreign Months Days 1⊠M 2□ F Washington, DC 70 Yrs. 577-34-2469 Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. inside City Limits MD Howard Woodbine 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 16391 A.E. Mullinix Road 21797 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give WWII Yeer or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Bleck, Whita, atc. 1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collaga (1-4or 5+) Plumbing Contractor Construction 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Bo Cumberland Margaret Newby 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16391 A.E. Mullinix Road Woodbine, MD 21797 Mrs. Charlene S. Cumberland 20b. Pleca of Disposition (Nama of cematary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Memorial Garden 12/31 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Halght. Sykesville, MD 21784 (410)-795-1400 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Intarval Batween Onset and Deeth Immediata Causa (Finel GELL LANGE CANGER 5 MONTHS disaasa or condition rasulting in daath) Sequentielly list conditions, if eny, leading to immadiate causa. Entar Undarlying Cause (Diseesa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence ot): Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed?

**Physician** /Medical Examiner

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physician the buriel

ate hes been signed by the atter page 2 should be detached for

this certificate

Hospital or Attending Physician: 24 hours effer death.
Funeral Director: After this certificaletely filled in by the funeral director;

To the Hospital or within 24 hours of To the Funeral D

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

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Herns 23a death

pernit. Pages 1 and 2 should be filled within 72 hours after to Depertment of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or ites any Injury or other traumatic event, the Medical Examina page.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

traumetic event, the Medical Examiner must be notified at

the Marylend

Examiner Physician/Medical þ Completed Be edicai Certification: To

completion of ceuse of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one)

lome	5 Residance	6 ☐Other (Specify

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing F 28b. Tima of 28c. Injury at Work?

28d. Describe how injury occurred

1 Yes 2 No 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian (Check only one)

Certifying Physician: To tha best of my knowledga, daeth occurred at tha tima, data and placa, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) end mennar stated.

29c. License number

29d. Dete signed (Month, Day, Year)

31. Data tiled (Month, Day, Year)

29 p. Signa ura end titla of certifier

25. Was case referred to medical

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investigation

8 Could not be datarmined

DEC 3 0 1998

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27. Mannar of Deel

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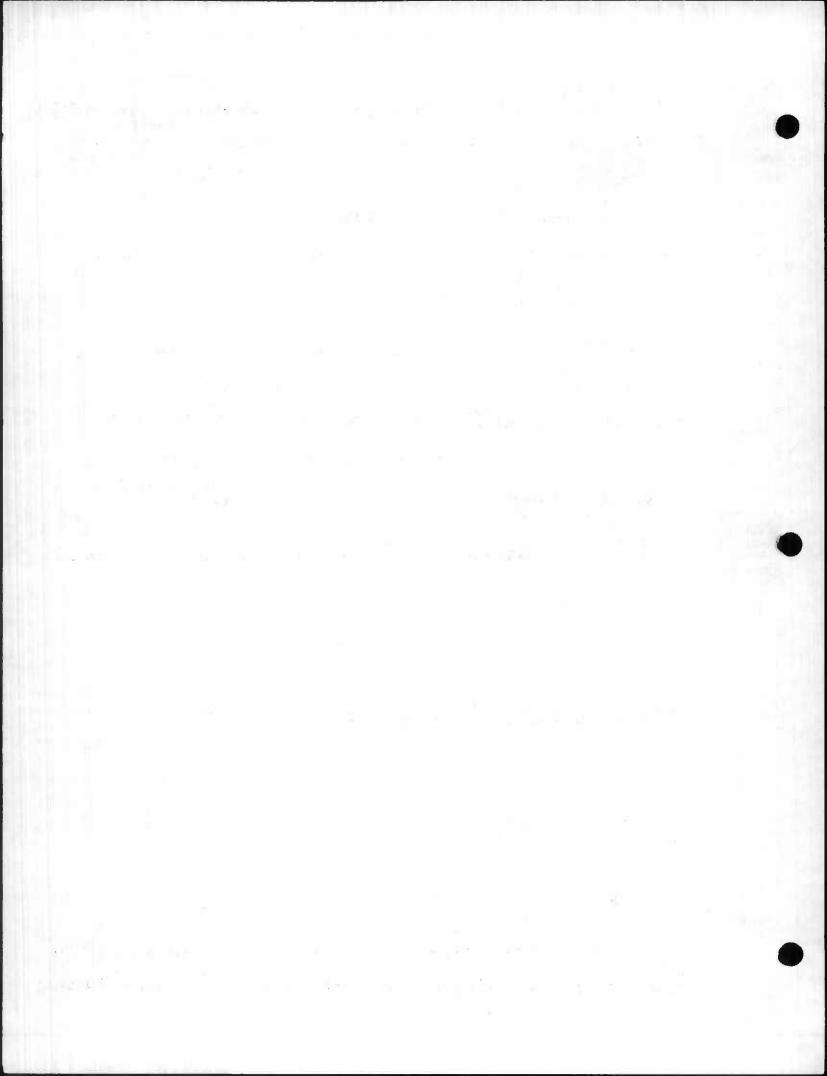
4 ☐ Homicide

32. Registrar's Signetura

of deeth (Item 23a) (Type, Print)

9707 MENCAL KNOOR DEINE

State Registrar



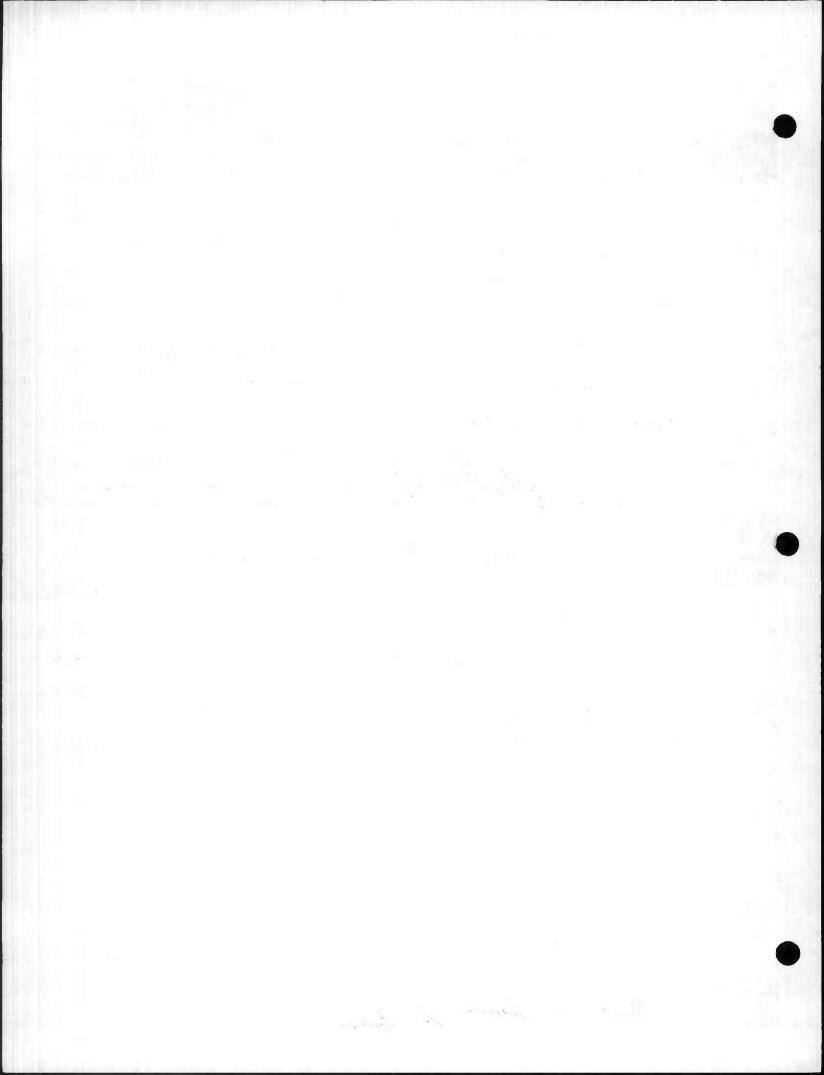
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 27, 1998 0306 hrs December Catherine Cecelia Coxe /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital of Cecil County **Elkton** ff Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1DM 2XXF Yrs. 219-10-3233 80 Director September 8, 1918 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inaide City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at YYes 2 No Director Cecil Maryland Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21913 United States 136 South Bohemia Avenue items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No 1f Yes, Give Yeer or Detes: 11. Maritai Status Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. Peges 1 and 2 should be filed within 72 hours effer in ant of Heelth and Mental Hygiene.
int: If Item 27 Ia merked other than "natural", or ite 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify 3 → Widowed 4 Divorced White Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Food Service (School System) Board of Education 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname) Leona Yates Marion Earl Pearce Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Peges 1 end 2 to Department of Heelth er Important: if item 27 ta any Injury or other traugonce. Etta Coxe Jackson - Daughter 4025 Maonor House Dr., N.E. Marietta, Georgia 30062 20b. Place of Disposition (Name of cemetery, cremetory or other place) December 30, 1998 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery Chestertown, Maryland Name and Address of Eacility ellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Funerel Service License M-00937 William L. King, Jr: 226 East Main Street, Cecilton, Maryland 21913 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequance of): Physician/Medical Examiner neumonia physician end s the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of) P.O. Box 68760, Due to (or as e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t Complete Heart Slock 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by ite Reval Failure 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was casa refarred to madicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 70 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA sal or Attending Physics efter deeth.

In Director: After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Pending invastigation 1 Naturai 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of tnjury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and piace, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and piaca, and dua to the cause(s) and menner stated. Medical (Check only 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 130291 Quelho 30. Name and addrass of person e-completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) DEC 3 1 1998 32. Registrar's Signature State Sparker Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** Earl Price Cronshaw December 16, 1998 3:23 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Corsica Hills Nursing Home Centreville Queen Annes If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiaca (Stete or Foreign Country) **Funeral** t∰M 2□ F Days 217-36-0637 Yrs. Director 85 July 19, 1913 Barclay, Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examinar must be notified at 1 ☐ Yes XXNo Director Maryland **Queen Annes** Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6408 Church Hill Road 21620 United States Funerai 11. Maritei Stetus 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 No If Yes, Give Yeer or Datas: Baltimore, Maryland 21215-0020 1 Yes 2√No Specify: Specify: White py 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry filed within 7 Hygiene. d 2 should be filed within 7 is marked other than "r Elementery/Secondery (0-12) Collage (1-4or 5+) Yard Manager Lumber Company 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Edward Sylvester Cronshaw Katie Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Heelth and Important: If Item 27 is m any Injury or other traum Mrs. Dorothy M. Cronshaw/Wife 6408 Church Hill Road, Chestertown, Maryland 21620 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sudlersville Cemetery/December 20, 1998 Sudlersville, MD 21. Signeture of Funarai Sarvice Licensee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Physician /Medical Immediate Cause (Finel CARDIO pulnurary Annest
Due to (or es e consequence of): diseese or condition resulting In deeth) Examiner Respiratory Failur Due to (or es e consequence ot): buriel-tran Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Duelo (or as a consequence of): physician s the buriel Box 68760 Physician/Medicai P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown CHARGIE A friend To be Alla fin, An Lewis clerate Division of Vital Records, 24b. Wera autopsy findings available prior to completion of causa of deeth? Vascular Sisease, Multiple Transmit 24e. Wes en eutopsy performed? Ischemic Attrope 1 Yes 2 THO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA 27. Menner of Deeth To the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funera 28e. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No Investigation None 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 29a. Certifier i 🗹 certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated.

29c. License number

12-23889

946 WAShington Ave, Clos lartown med 21420

29d. Dete signed (Month, Day, Year)

State Registrar

29b. Signeture and title of certifier

31. Dete filed (Month, Dey, Year)

30. Name and address of person who complated causa of death (item 23a) (Type, Print)

32. Registrer's Signature

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DEC 1 8 1998



State of Maryland / Department of Health and Mental Hygiene | | | | 2 | |

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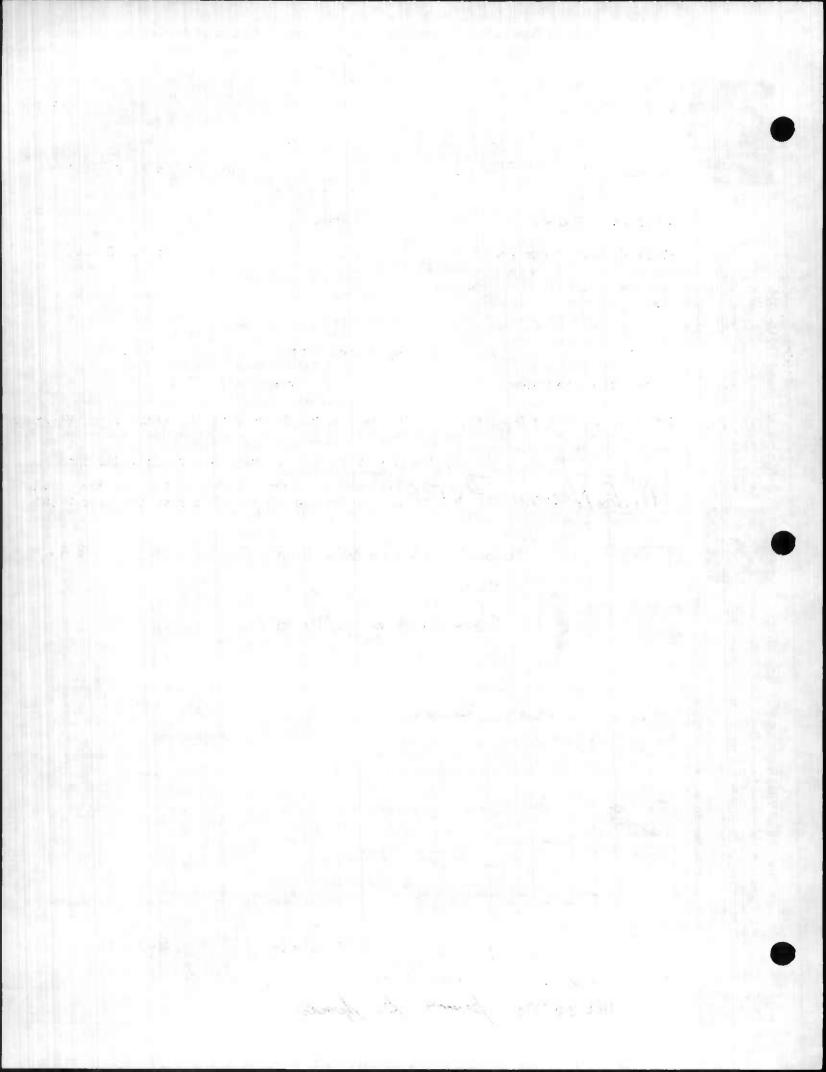
State Registrar

R. Bruce Helmly, MD, 403 Marvel Court, Easton, Maryland 21601 31. Dete filed (Month, Day, Year)
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30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

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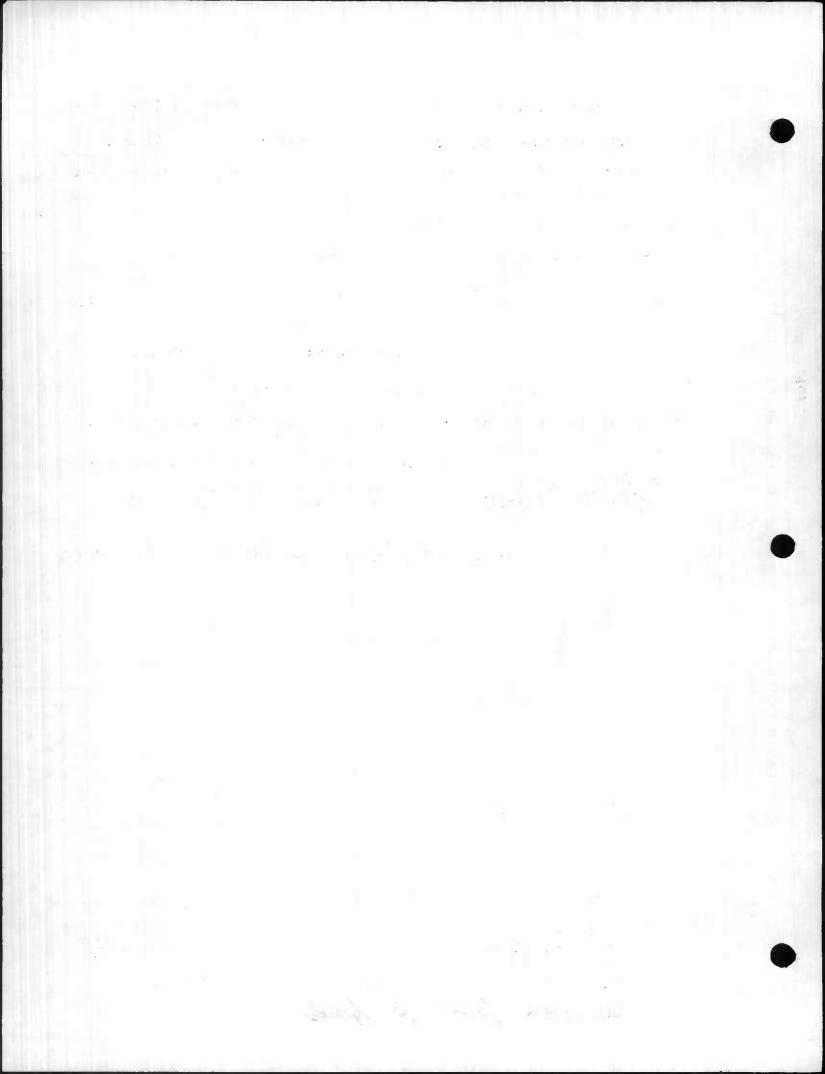
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Certificate of Death

COPPER, LOUIS

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neral ector	217-30-8132	7. Age (In yrs. In 87	Yrs. If Und Month:		der 24 Hrs. rs Min. (M Fe	ite of Birth conth, Day, Yo b.13,1	911 N	9. Birthpl Count Maryl	ace (State or Foreig and	
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36	17. Father's Name (First, Middle, Last)			18. M	other's Name (First	t, Middle, Mai	iden Sumam	0)		
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once. To Be Comp	20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Re		iece of Disposition (Nemetery, crematory or	lame of r other place)	Dat	200	c. Location -	City or To	wn, State	
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Š	21. Signature Funeral Service License		22. Name	and Address of Fa		77				
8	Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601									
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ertifi	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	ory, office	28t. L	city or Town, S	et and Numb State)	er or Hura	i Route Number,	
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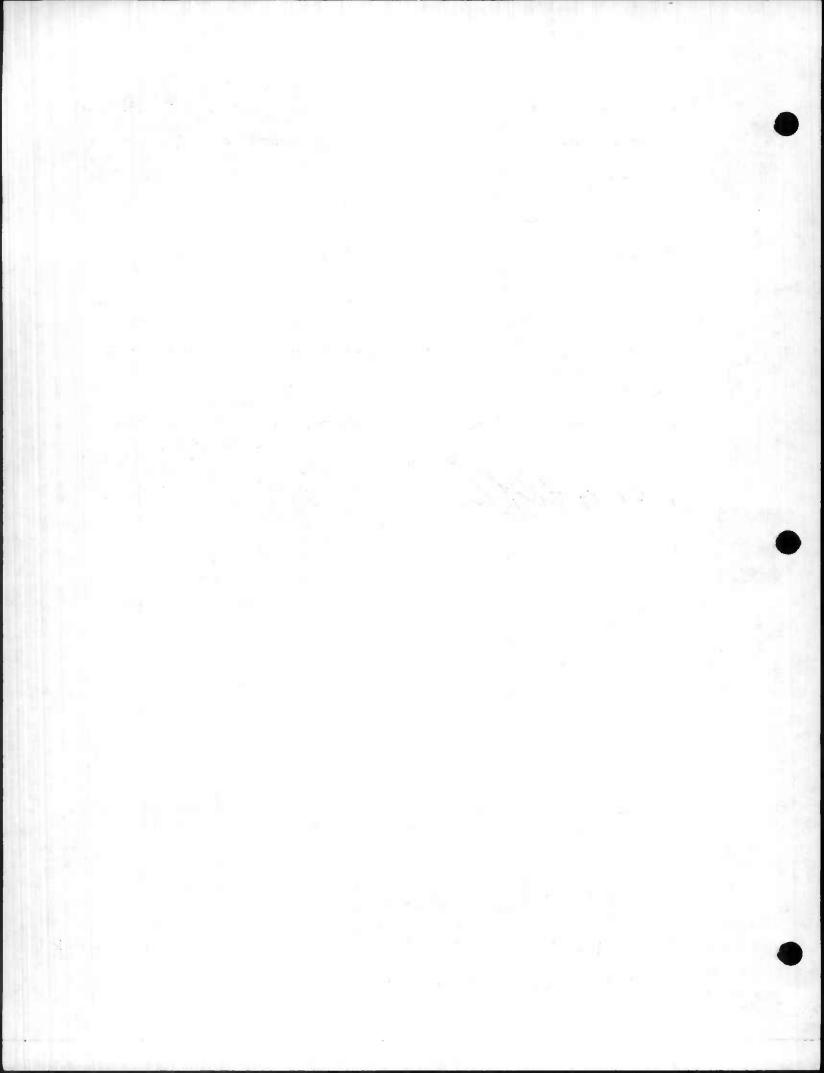
State of Maryland / Department of Health and Mental Hygiene

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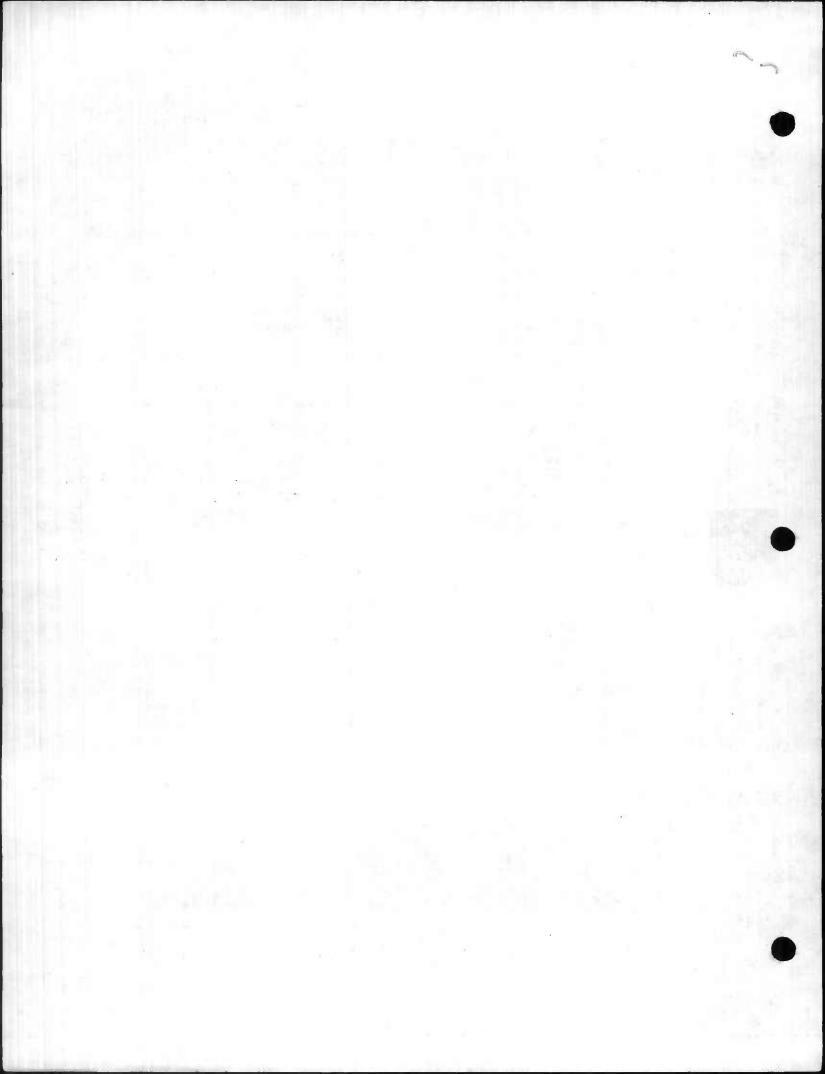
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🍳 🤉 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month enise **Physician** +vankly December 20 1998 2058 /Medical 4baCity, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner Daltimore Hopkins John Hospita Baltimore City If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 10 M 20 F 241-56-1990 Director 59 Feb 4, New York Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 No Yea 2 No Director Pennsylvania Lucerne Drums 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 105 Covey Ln 18222 death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black White etc. filed within 72 hours after Hygiene. Wher then "natural", or its 1 ☐ Yes 2 ☐ No 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiers Important; if item 27 is marked other that any holury or other traumatic avant, the page. 4 Industrial Engineer Engineering 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Warren Denise Lorena Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Billie A. Denise/Wife 105 Covey Ln, Drums, PA 18222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory Dec 24 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a, Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Week diseese or condition resulting in death) Examiner Examiner ancreatic Cano physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760 Physician/Medical Due to (or es a consequence of) attending f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 2 No 2 3 Probably 4 Unknown signed t Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu page 2 : has 1 ☐ Yes 2 ☐ No certificate Division of Vitai To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Unpatient Medical Certification: To 2 ER/Outpatient 3 DOA ete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Netural 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) end manner steted. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Nema and address of person who completed cause of death (Item 23a), (Type, Print) 600 NOH 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State DEC 29 1998 Registrar

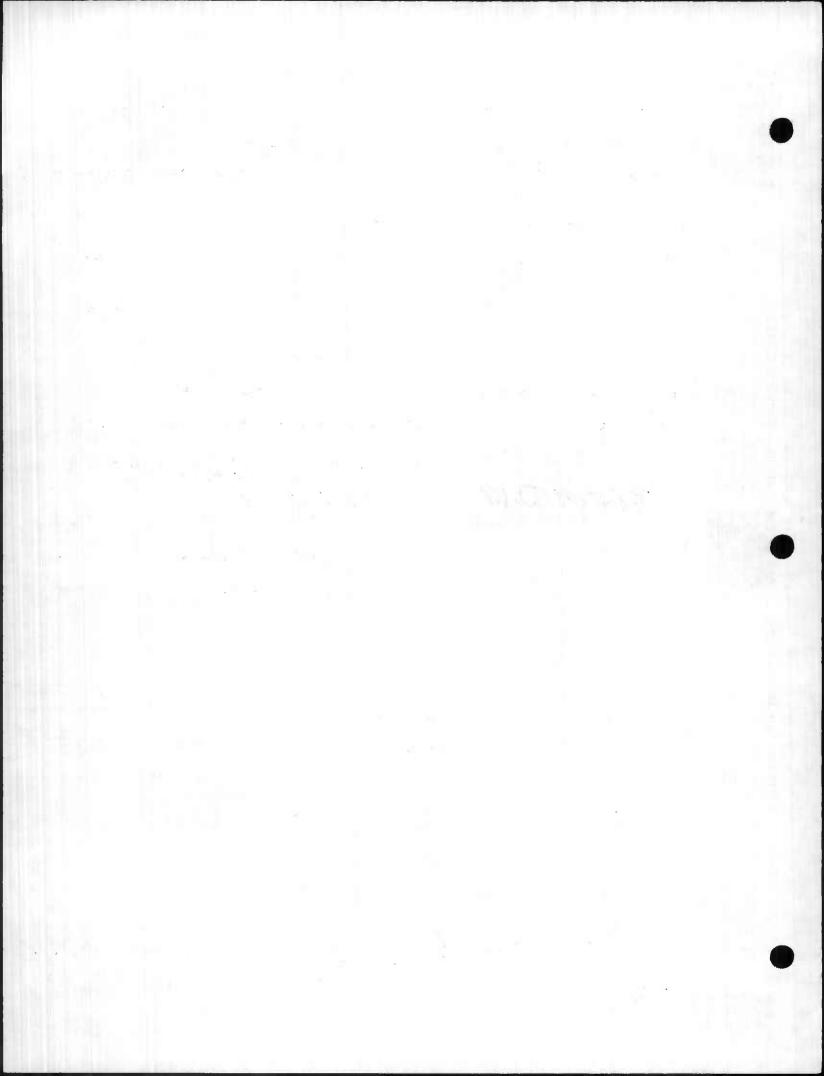
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State of Maryland / Department of Health and Mental Hygiene 8

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	10a. State	10b. Co			10c.	City, Town or	Location		-				10d. Inside City L
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10	Josep	h DiGi	ulian						Stefan	ia Cas	tellir	ní	
	19a. inform	ant's Name/Rela	tionship (7	ype, Print)		19b. Ma	alling Address (S	Street e	and Number or R	ural Route Numb	er, City or T	own, State, 2	Zip Code)
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		d of Disposition				b. Place of Dis	sposition (Neme	of place	a)	Date	20c. Loca	tion - City or	Town, State
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State of Maryland / Department of Health and Mental Hygiene

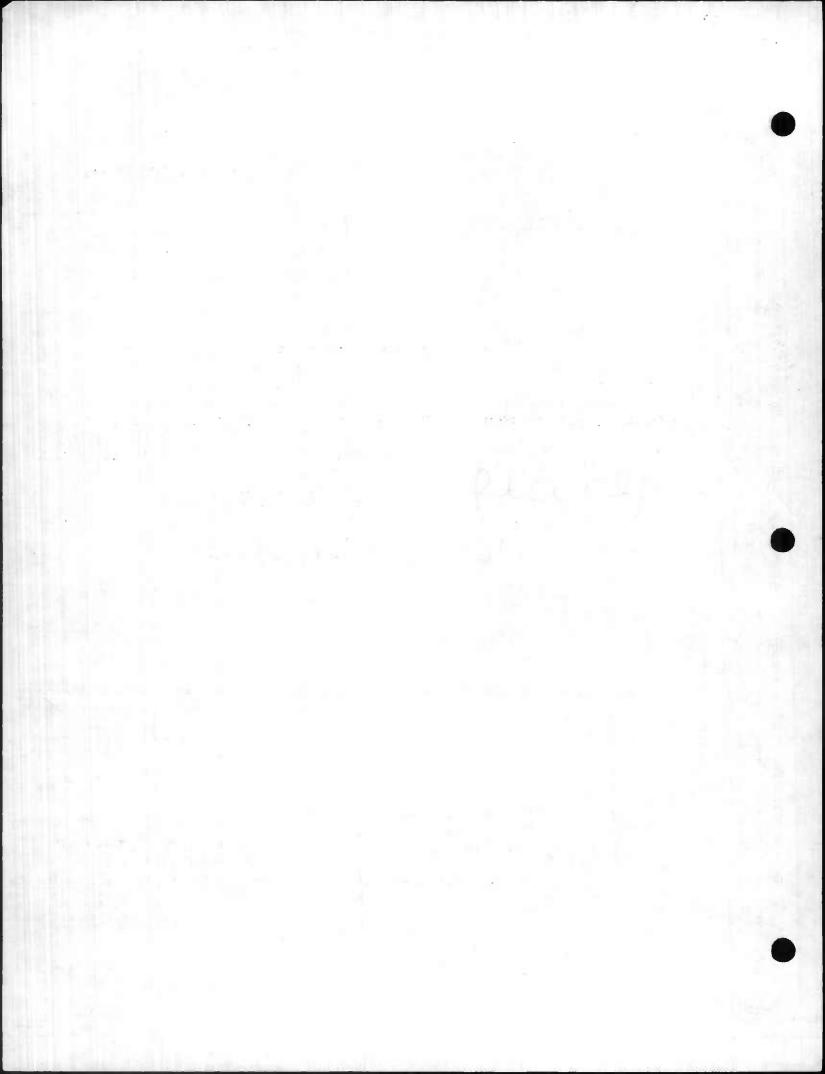
Physician
/Medical
Examiner

TROY	DUGGER			Cei	rtificate (	of Death	,	Reg. No.	41	200
		1. Decedent's Nama (First, Middle, Las	)				2. Data of Dea	th		3. Tima of Deeth
	Physician /Medical	TROY A. DUG	GER JR.				Month DEC.	19, 19	Year 98	0340 AM
	Examiner	4a Facility Nama (If not institution, giva				4b. City, Town, or	Location of Death	4c. County	of Death	
(1)		PRINCE GEORGES H	HOSPITAL CEN	TER		CHEVER		PRIN	CE GEC	RGES
	Funeral Director	5. Social Security Number 6. Sec 579 04 6345	X 7. Age (In )	yrs. last birthday) 19 Yrs.	If Under 1 Y Months De			, Year)		ce (State or Foreign
	D A	10a. Stata 10b. County	10c.	City, Town or Lo	cation				10d	I. Inside City Limits
	or 28a-1 ahow a notified at	MD. P.G		HYAT	TSVILI	E				1 XYas 2 No
	rec noth	10e. Street and Number			10f. Zip Co	ie .		l0g. Citizan of V	Vhat Country	17
	23a o	717 CHILLUM RO	AD #201			20783		USA		
21215-0020	ors after dealer, or thems	11. Meritat Status  111 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever In Armed Forces?  1 Yas 27 No If Yes, Giva Yaar or Datas:		Was Decedent if Yes, specify to 1 ☐ Yes 🂆	of Hispanic Origin? () Cuban, Mexican, Pua No Specify:	Specify Yas or No- rto Rican, atc.)	14. Race - American Indian, Black, Whita, atc. Specify: BLACK		c.
0	ted in	15. Decedent's Edu		18a, Deced	tent's Usual O	ccupation one during most of wo	16b. Kind of Business/ir			stry
21	led within 72 ho lygiene. Ner then "naturn 14, Tre Medical Completed	(Specify only highest grad	College (1-4or 5+)	life. I	DO NOT use re	OT use retired)				
64 .	Hygien the the Tr. Tr.	12		CABL	E TECH	INICIAN			PVT.	
Maryland	E S S S S S S S S S S S S S S S S S S S	17. Fathars Nama (First, Middle, Last)				18. Mothar's Na	ma (First, Middle,	Maiden Suman	ne)	
Z :	2 should be filled within and Mental Hygiene. Is marked other than raumatic event, the H						RETA JOI			
N N	lo m le m reum	19a. Informant's Name/Relationship (T				reet and Number or R		The state of the s		
	1 and 1 Health em 27 Wher tr	LORRETA JOHNSON		b. Place of Dispo		JM RD. #2	Data Data			
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altimore,	thent thent tant: H	4 Donation 5 Other (Specify,					20/90	WASHI	NGTON, D.C.	
0	Baltimore, Maryland 212: permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if them 27 is marked other than eny injury or other traumatic event, tress once. To Be Comp	21. Signature of Funeral Sarvice Licens	Sat In.	1	WATSON	ddress of Facility  I. F. H.IN  4th ST.		20010		
M,		23a. Part1. Elitar the disease, or comp shock, or heart fallure. List only of	lications that caused the d	leath. Do not ent	er the mode of	dying, such as cardia	c or respiretory ar	rest,	i In	pproximate nterval Between
	Physician /Medical Examiner	Immediate Causa (Finel diseasa or condition rasulting in death)	Mult	o (on as a consec		ab Wa	ound s	5		Onset and Death
	iteste be assected sphysician and se the buriel-transit edical Examiner		h							
	tricate be executed g physician and es the burlei-transit fedical Examir	Sequentially list conditions,	Dua to	o (or as e conseq	luence of):					
68760,	physician the burle	Sequentially list conditions, if any, leeding to immadiate cause. Enlar Underlying Causa (Disease or injury that initiated events resulting in death.)	c							
387	di the	that initiated events rasulting in death) Last  Dua to (or as a consequence of):								
	ding		d						1	
Вох	ettending pl for use est clan/Mec						COL DIA			
0	y the check the	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying caus	a given in Part I.		obacco uss co ∕ss 2□ No	3 Probe	he cause of death?
0	y P						. 10	ISS ZLINO	3 Proba	bly 4 Donknown
Vital Records,	The lew requires that the death certicate has been signed by the ettending pegs 2 should be detached for use Completed by Physician/M						24a. Was	an autopsy		autopsy findings
00	e de de			- 367			репо	med?	comp	able prior to pletion of cause ath?
8	omp omp						100	es 2 No	15	
	yeclen: The lev s certificate has director, pega 2 To Be Comp	25. Was case referred to medical				26 Place of De	eath (Check only o			20110
>	his cert il direct	evaminer?	lospital:	ER/Outpatier	nt 3D DOA	Other	Homa 5□ Rasid		er (Specify)	
of		27, Manner of Death	28a. Data of Injury (Month, Day Year	28b. Time of	The second second	Injury at Work?	28d. Describe h			1 4
Division	Attending Physician: r death. ector: After this certific by the funeral director, iffication: To Be (	1 Naturat 5 Panding 2 Accident invastigation	12/19/98	0245	M	1 Yes 2 1 No	Subi	ect "	Stab	bed
<u>×</u>	by th	3 ☐ Suicide 6 ☐ Could not be determined	28a. Place of Injury - A building, etc. (Spe	t homa, farm, str	eet, factory, of	ice	28f. Location (S City or Tow		er or Rural F	Toute Number,
0	Central State of Stat			1	und	, Bladensbu		St NB	· Wa	shareton, OC
	To the Hospital or Attending Private Hospital State the Completely filled in by the funeral Medical Certification:	29a. Cartifiar (Check only one) 1 Certifying Physical Example 1 Ce	elclan: To the best of my l ner: On the basis of axam and mannar stated.	knowledge, death nination and/or in	occurred et the vestigation, in r	e time, data and plac ny opinion, deeth occ	e, and dua to the curred at tha tima,	cause(s) and madata and plece,	anner as stat and dua to th	ed. ne cause(s)
	Withir Comp	29b. Signatura and titla of certifier			29c. Li	cense number	29d. Data signed (Month,			
	3	1 ( Pettone	~ M.D.			O.C.M.E		DEC.	19, 19	98
	0	30. Name and address of person who co	ompleted cause of death (	ttem 23a) (Type,	Print)					
		Joseph Pe	Staner	111 Pen	n Stree	et, Baltim	ore, Mar	yland 2	1201	49 5 5 1
	State	31. Data filed (Nonth, Day, Year)	32. Registrar's Si	ignature	-					

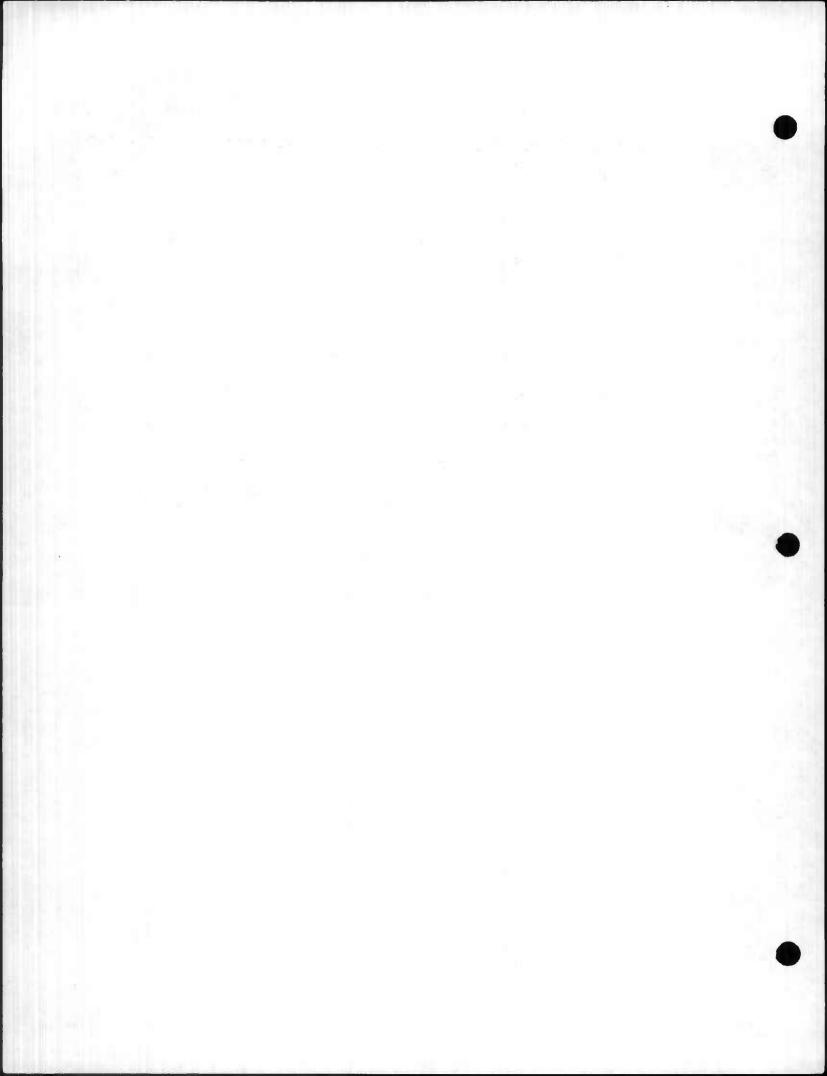
**DHMH 16 Rsv 6/95** 

Registrar

DEC 29 1998



ysician	_	Decedant's Name (First, Middle, I	Last)	VI 1		-			2. Date of De Month	Reg. No. ath Day	Ya		Tima of Death
<b>Medical</b>	_	Carolyn	J. DuPree							5/19	98		2:10 A
aminer	1 4	4a. Facility Nama (If not institution, give street and number)  4b. City, Town, or Locate											
	4	SHADY GROVE ADVENTIST HOSPITAL ROCKVIL  5. Social Security Number 6. Sax y 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.								MONTGOMERY			
eral ctor		5. Social Security Number 6. Sax 1 M 2 F 7. Age (In yrs 1 M 2 F 87)  Usual Rasidance of Decedant			Months Day		Hours	Min.	8. Data of Bir (Month, Da 9/06/1	y, Year) 911	9.	Birthpiaca (Steta or Fore Country)     GEORGIA	
11	-	10a. Stata 10b. County		10c. City, To	own or Loc	cation						10d. I	nsida City Lin
to to	5	MD MONTGOMERY GAITHERSBURG											□ Yas 2
lirec	3	10e. Street and Number 10f. Zip Coda								10g. Citiz	zan of What	t Country?	
dia le	2	109 ORCHARD HI		20878				8		US.	A		
the Medical Exercises must be notified at ompleted by Funeral Director		11. Marital Status  1 □ Nevar Married 2 □ Married  1 □ Yas 2 ☑ No			U,S. 13. Was Decedant of Hispanic Origin? (Spec If Yes, specify Cuban, Maxican, Puarto R				ecify Yes or No Ricen, atc.)	- 1	14. Race - American Indian, Biack, Whita, atc.		
ed by		3 ₩ Widowed 4 □ Divorcad If Yas, Give A Year or Datas:			1 ☐ Yas 2 ₹ No Specify:					Specify: BLACK  16b. Kind of Business/Industry			
rt, the Medical		(Specify only highest s Eiamantary/Secondary (0-12)		(Give kind of work done during most of working life. DO NOT use retired)				ing	Tou. Airid of business/industry				
T NO		Elamantary/Secondary (0-12) Coilega (1-4or 5+) 2 SECRETARY					RY	.Y			PUBLISHING		
event, Be C		7. Fathar's Nama (First, Middla, La	st)				18. Moth	ar's Nama	(First, Middle	Maidan	Sumama)		
		SMITH JENNINGS	, SR.					ANNI	E REID				
mne		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing	g Addrass (Street	end Numb	er or Rura	al Routa Numb	er, City or	Town, Stel	te, Zip Coo	fa)
other traumatic	-	DENISE R. DUPRE	E-JONES			RCHARD H	ILLS	DRIV					878
	2	20a. Method of Disposition 1 ☐ Burial 2 XX cremation 3		00000	tary, crem	atory or other pla	ce)	1	Date	20c. Lo	cation - City	y or Town,	Stata
any injury or once.		4 □ Donation 5 □ Other (Spec	**	FORT		OLN CREM			12/28/9	8 BR	ENTWO	OD MA	RYLAND
once.	1	21. Signature of Funaral Service Lic	ensee		22.	Nama and Addra	iss of Facili		ES-RINA	LDT	FUNER	AL HO	ME. IN
	resulting In death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):												
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	State	of Marylan		artment of <i>rtificate o</i>					-3		
Decedent's Neme (First, Middle,	Last) ;		061	incate c	Deali		2. Date of Dec	Reg. No.		3. Time of Death	
Alisa	Diaz						Month	Dey er 24,	Year	07:35 a.m	
Facility Neme (If not institution,		ımber)			4b. City, To	wn, or L	ocation of Death				
	ventist	Hospit	a1		Tako				tgom		
	6. Sex 1 □ M 2 🗓 F	7. Aga (in yrs.		If Under 1 Ye Months De	ar If Under		8. Dete of Birt (Month, De) Dec . 24	, Year)	9. Birth	place (Stete or Foreign intry)	
suel Residence of Decedent		10- 04	. Town and a							and to the Oile Limite	
MD 10b. County MD Montg	y, Town or Location Liver Spring						10d. Inside City Limits 1 🏋 Yas 2 🗆 No				
e. Street and Number				10f. Zip Code	е			10g. Citizen of	Whet Cou	intry?	
11447 Lockwood	Drive, #	104		2090	4			US	A		
Marital Status  12. Was Decedant Evar In L Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give			'	If Yes, specify Cuben, Mexican, Puerto Rican, etc.)  Black,					ck, White	- American Indien, s, White, etc. Black	
3 Widowed 4 Divorced	Yaer or E	Detes:							DI		
15. Decedent's (Specify only highast Elementery/Secondary (0-12)	16e. Deced (Give life. I	b. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Indus						ndustry			
N/A	N/	A		N/A					/A		
Angel Milciade						ar's Nem elen	e (First, Middla, e Mari				
Suseela Drumhel	ler, Bir				11 Ave	., T	akoma P			0912	
a. Method of Disposition  1  Buriei 2 Cremetion 3  4 Donation 5 Other (Spe.  Signeture of Funerei Service LI	ecify)	State	Linco	East D	olece) etery dress of Fecili Deer Pa	ty De rk D	Vol Fun rive		od,	Maryland	
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**Physician** /Medical **Examiner** 

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the attending 950 for

ate hes been signed by the page 2 should be detached

the funeral director,

filled in by

To the Hospital or Attending Physician: Tha law within 24 hours after death.

To the Funeral Director: After this certificate hes

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest

23e. Pert1. Enter tha disees shock, or heart failure.

Immediete Cause (Finel disease or condition resulting In deeth)

1. Decedent's Neme (First, I

4a Facility Neme (If not insti

Usuel Residence of Deceder

10e. Street and Number

Angel Milci 19a, Informant's Name/Raia Suseela Drum 20a. Mathod of Disposition 1 ☑ Buriei 2 ☐ Creme 4 Donation 5 Oth 21. Signeture of Funerei Ser

15. Dec (Specify only h Elementery/Secondary (0-N/A 17. Fathar's Nema (First, Mic

10a. Stete

Director

Funeral

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Completed

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11. Marital Status

Washington 5. Social Security Number

**Physician** 

· /Medical

**Examiner** 

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Depertment of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other treumatic evant, the Wedden Exempton.

25. Was case referred to me examiner? 1 Yes 2 No

27. Menner of Deeth

1 X Naturel

3 Suicide

2 Accident

4 Homicide

28e. Dete of Injury (Month, Dey Year) 5 Pending investigation

28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the bests of axamination and/or invastigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. 29c. Licensa number

29b. Signature and title of certifiar

D0052750

29d. Data signed (Month, Day, Year)

completed cause of deeth (Item 23a) (Type, Print) 30. Name and address of person what

M.D., WAH, 7600 Carroll Ave., Takoma Park, Lincoln Ferguson, 20912 MD

State Registrar

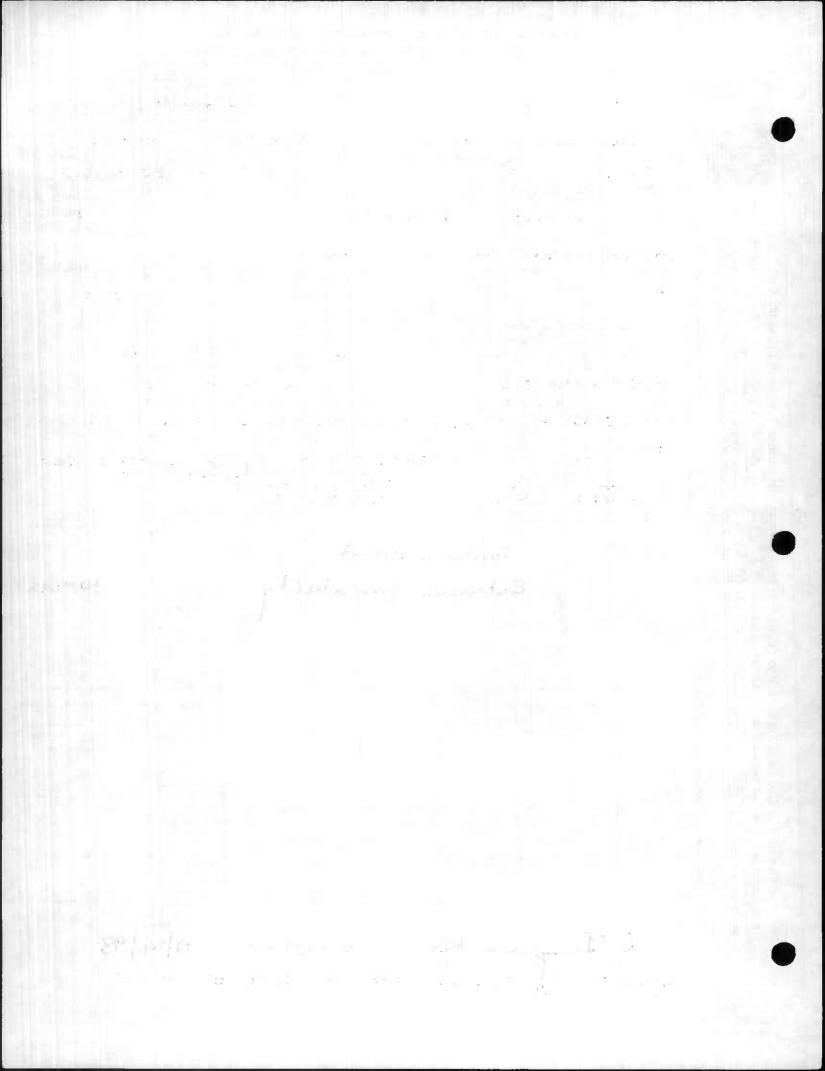
31. Dete filed (Month, Dey, Yeer) **DEC 28** 1998

6 Could not be determined



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**DHMH 16 Rev 6/95** 

will-omin't year in 1961 in 2 w 5 1 1 1 \* \* \* · · · · · THE RESERVE NO. 15. 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Vaar Month Vernon Devan 2:43 m December 29, 1998 4a. Facility Nama (tf not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5 Social Security Number 6. Sax Birthplaca (Stata or Foraign Country) Days 1⊠M 2□ F 198-18-6131 74 Sept. 10, 1924 Pennsylvania Usual Rasidance of Dacedant 10a Stata 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland | Montgomery Derwood 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 17808 Vinyard Lane 20855 United States 11. Maritai Status 12. Was Dacedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1XYas 2 No If Yas, Giva 1944 — Yaar or Datas: 1974 1 ☐ Nevar Marriad 25N Married 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 5+ Vice President Computer Corp. Computer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Vernon Alger Devan Henrietta McClellan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zio Code) Constance M. Devan (Wife) 17808 Vinyard Lane, Derwood, MD 20855 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 1/6/99 Arlington, Virginia
22. Nama and Addrass of Facility DeVol Funeral Home 21. Signatura of Funaral Sarvice Licenses 10 East Deer Park Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Batween Onsat and Death immediata Causa (Finai 8 hours disaasa or condition rasulting in daath) Dua to (or as a consequence ot): Dua to (or as a consaguance of): sa givan in Part I. 23b. Did tobacco use contribute to the cause of geath? 1 | Yes 2 | No 3 | Probably 4 Unknown 24a. Was an autopsy performad? 24b. Wera autopsy findings available prior to complation of cause of death? t Yes 2 No 1 □ Yee 2 □ No Death (Check only one) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

**Physician** /Medical **Examiner** 

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page 2 s

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Ne Hospital or Attending 24 hours after death.

within 2 To the ş

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The law requires that the death certificate be executed

Box 68760,

P.O.

Records.

Division of Vital or Attending Physician: Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

Part ii. Otl

27. Mannar of Death

29a, Cartifian

(Check only

permit. Pages Depertment of Important: If it eny Injury or o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Director

Funeral

by

Completed

Be

the Maryland

filed within 72 hours efter

Pages 1 and 2 should be filed within 72 honent of Health and Mental Hygiene.
Int: If item 27 is marked other than "naturary or other traumatic event, the Medical

Baltimore, Maryland 21215-0020

Saquantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last

ner significant conditions contrib	uting to death but not rasulting in tha undarlying caus
ipidemia	. hypertension

25. Was case referred to medical	26. Place of

Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Dascribe how injury occurred

Mannar of Death Naturai Accident	5 Panding invastigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury M	2
3 ☐ Suicida	6 Could not ba datarmined	28a. Place of Injury - At I	noma, farm, straat, tac	tory

28c. Injury at Work? 1 Yes 2 No

, offica building, atc. (Specify)

281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 10 certifying Physician: To tha bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

	(Check only one)		d/or Invastigation, in my opinion, daath occurred at th	
29b	. Signature en	ditla of cartifiar	29c. Licensa number	29d. Data signed (Month, Day, Year)
	1	X ()	211001	1 -0 1

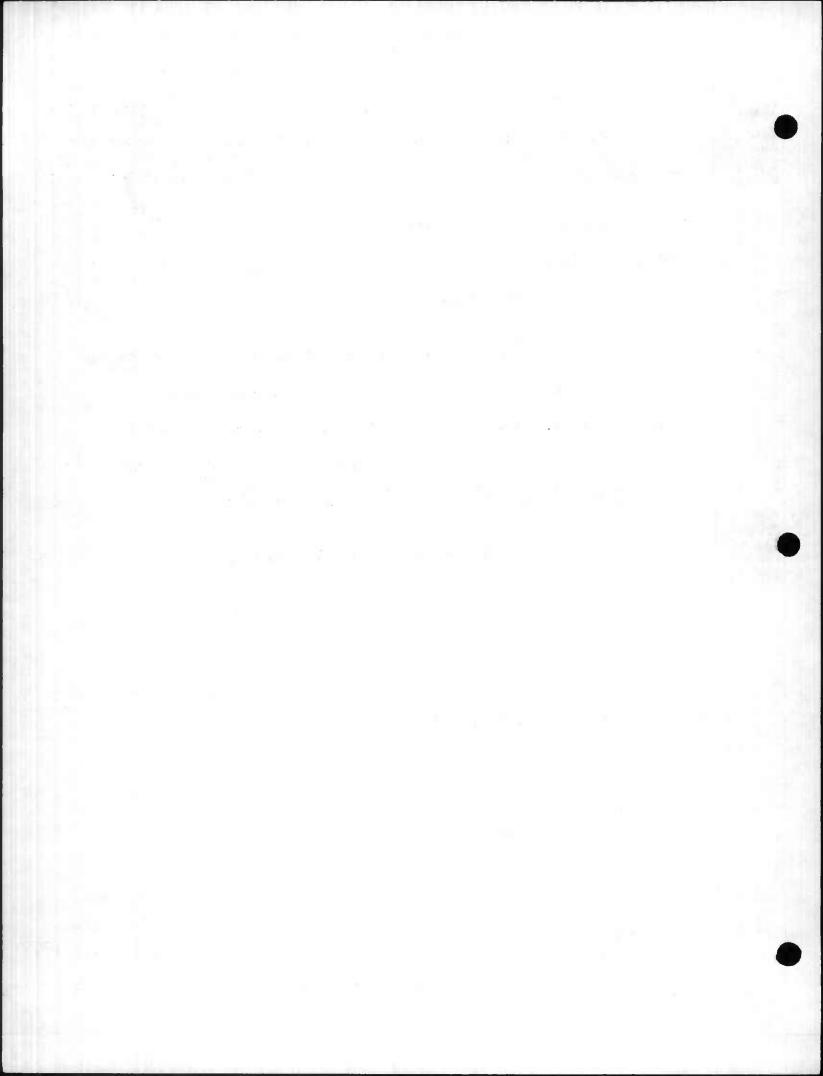
DEC 3 1

29c. Licensa number 29d. Data signed (Month, Day, Year)

December 29

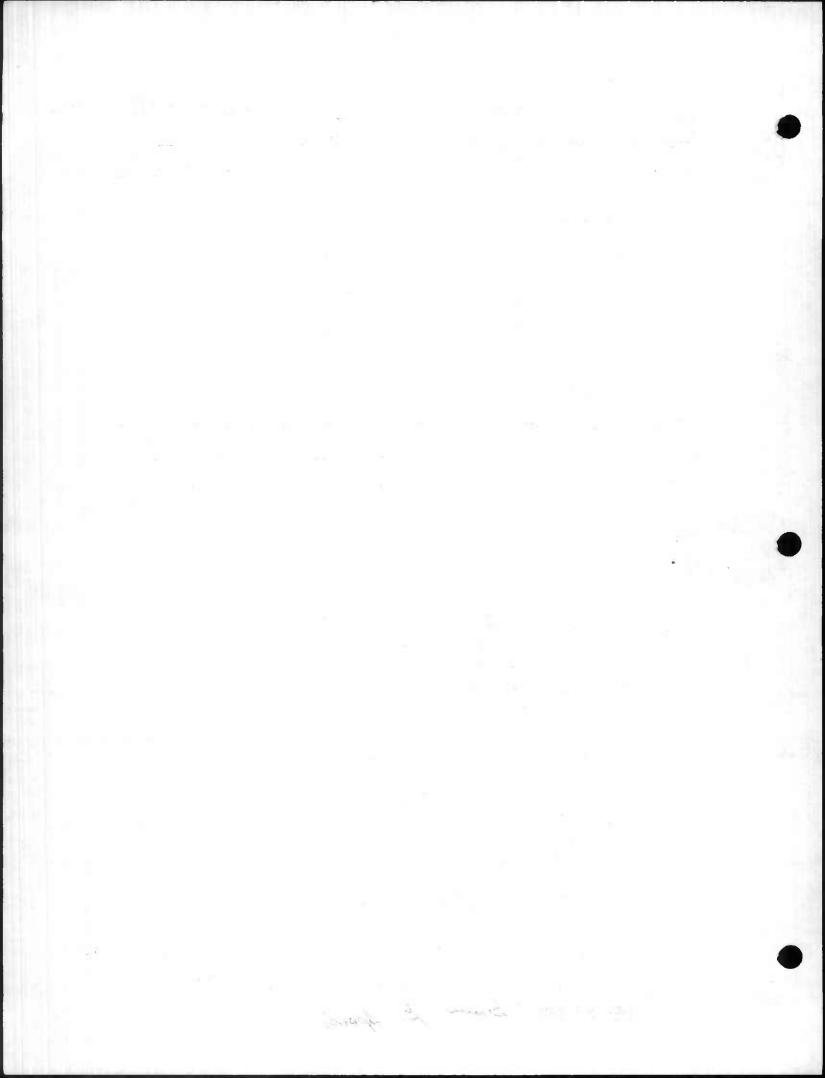
30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

Shady Grove Rd., Rockville Fried Jennis man 31. Data tiled (Month, Day, Year) 32. Registrar's Signatura

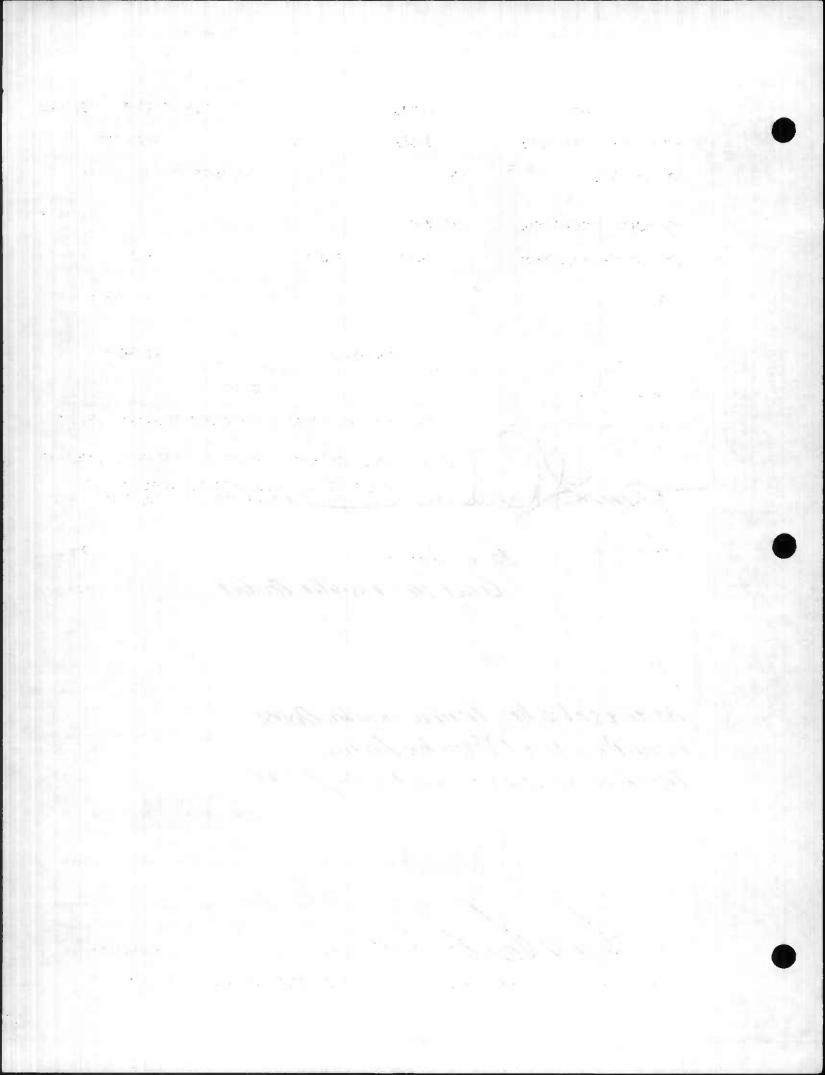


	1. Decedant's Nama (First, Midd	dia I aati		Cei	rtificate of	Dealli	2. Date of D	Reg. No.		2 Time of David
ian	Ruth Anna Rade		ring				Month	Day	Year	3. Time of Death 8:00p.m
cai ner	4e. Fecility Neme (If not Institution					4b. City, Tox	Decemb wn, or Location of Dec		L990 by of Death	0.00p.111
ner	Kent & Queen A	The state of the state of				Cheste:	rtown	Ken		
	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yeer Months Days		24 Hrs. 8. Dete of B		9. Birtho	plece (Stata or Forei
Ш	218-10-5873	1□ M 21 F	70	Yrs.	months Days	Tiodis	March	irth 3, 1928	Mai	ryland
	Usuel Residence of Dacedent  10e. Stata  10b. Count	у	10c. Cit	ty, Town or Lo	cation				1	IOd. Inside City Limi
ō	Maryland Caro	line	Не	enderso	m					1 Yas 2□N
Director	10e. Street and Number	LINC	110	cilderac	10f. Zlp Coda			10g. Citizan of	What Cour	ntry?
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by Fu	1 □ Never Merried 2 □ Me 3 ☑ Widowed 4 □ Divorce	If Yas, G	iva		1□Yas 2XNo		, , , , , , , , , , , , , , , , , , , ,	Speci		
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Be	17. Fathar'a Nama (First, Middla	, Last)				18. Motha	r's Nama (First, Middl	a, Maiden Suma	me)	
To	Rufus Radcliff	e				Eve	lyn Lewis			
	19a. Informant's Name/Relation						r or Rural Route Num			Code)
	Thomas M. Dawk	ins/Son	20h E		Henderson (Name of	on Roa	d, Henders	1		Diete
	20a. Method of Disposition  12 Burial 2 ☐ Cremation		State	cematery, crer	netory or other pla			20c. Location		
	4 ☐ Donation 5 ☐ Other (3		Che		leld Ceme		12/22/9			
	21. Signature of Pyrherel Service	Licensee /	11 1	Me	llows, l	Helfen	bein & New	nam Fune		
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	rasulting in daath)	a			ACIDO	515			-	3 days
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DHMH 16 Rev 6/95

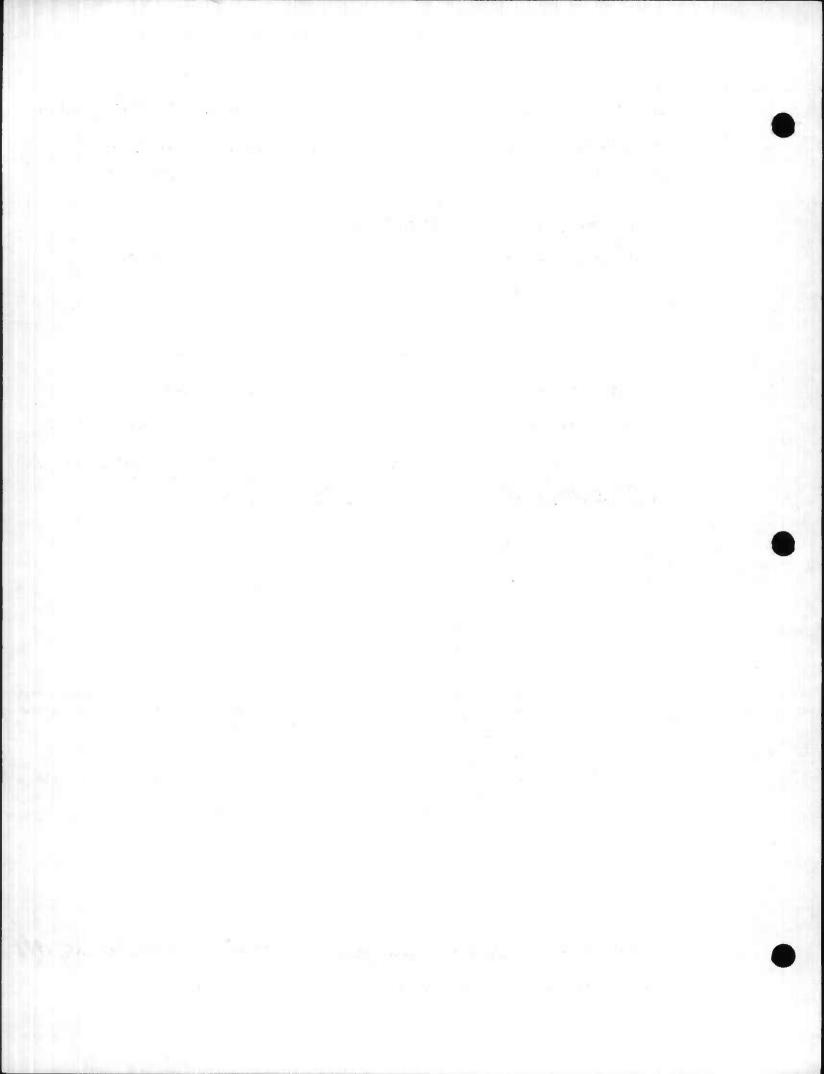


10000		Decedent's Nama (First, Midd	llo i est <sup>1</sup>		Cei	rtificate o	f Death	2. Data of Deat	eg. No.	3. Time of Death
Physic /Med		SAR	A		EISNER		T., 0, 7	Month DECEMBER	2.7 1998	5:14PM
Exam	iner	4a Facility Name (If not institution 5225 POOKS HILI	and the state of	number)	#604S		4b. City, Town, or I BETHESDA	Location of Death	4c. County of I	
Funera	1	5. Social Security Number	6. Sex	7. Aga (In y	rs. last birthday)	If Undar 1 Ye	ar If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (Stata or Foreign Country)
Directo	r	578 46 7323 Usual Residence of Decedent	1□M 2 <b>X</b> F	92	Yrs.		ys Plouis Will.	OCTOBER	121906 R	USSÍA
enylar show	-	10a. State 10b. County	1	10c.	City, Town or Lo	ocation				10d. fnslde City Limits 1 ☐ Yas 2 No
the M	Director	MARYLAND MONT	GOMERY	BE	THESDA	10f. Zip Code	9	10	0g. Citizen of Wha	
3a or		5225 POOKS HIL	T DOAD		#604S		814		USA	
death	Funerai	11. Marital Status		cedent Evar in			of Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No-	14. Race - /	American Indian, Vhita, etc.
2-UUZU 72 hours efter death with the Meryland natural", or flems 23a or 28a-f show dieal Examiner must be notified at	by	1 Navar Married 2 Mai 3 Widowed 4 Divorce	rried 1 Yas	2 X No Give		1 ☐ Yas 2 💢 N		o riioaii, aic.,	Specify: W	
72 hours	Completed		nt's Education est grade completed	d)	(Giva	dent's Usual Occ kind of work dor	na during most of wor		16b. Kind of Busin	ess/Industry
within	dw	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+)		DO NOT use ret	,		OWN HO	ME
		17. Father's Name (First, Middle	, Last)		H	MEMAKER		ne (First, Middle, N		MIG.
should be and Mental marked of marke	To Be	SAMUEL PLASKY					CELIA K	RIEGER		
Maryland d 2 should be file th end Mental Hy 7 Is marked othe treumatic avent		19a. tnformant's Name/Relation	ship (Type, Print)				eet and Number or Ru			
CENL	10	GILBERT M. EIS	NER/SON	(6)			COURT CHE			
Saltimore, semit. Peges 1 ar Department of Hee mportant: If Item:	4	20a. Method of Disposition 1 Burial 2 ☐ Cramation		n State		matory or othar p	Diace)	A	20c. Location - Cit	
permit. Peges Department of Important: If its any injury or or		4 Donation 5 Other (S	V	/ B	'NAT ISI			2/29/98 (	OXEN HILL	, MARYLAND
permit. Departm Imports any inju		21. Signature of Funeral Service	The (	1. 1/	D		GOLDBERG			
_		234 Part Finte the disease of	complications that	t caused the di	eath Do not ant	L70 ROCK	TVILLE PIK	E ROCKVII	LLE, MARYI	AND 20852 Approximate
Physiciar		23. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause on	each tine.						tntervat Between Onset and Death
/Medica	_	tmin-diate Court (Final disease or condition		2.000	ONIA					24 hours
Examine		resulting in death)	a		o (or as a consec	guence of):				
De tis	Examiner		a b	iner	banl	PASTU	INA Meck	lint		72 hours
be executed siclen and buriel-transit	хал	Sequentially list conditions, if any, teading to immediata		Due to	o (or as a consec	quence of):				t
siclen a buriel	0	if any, teading to immediata cause. Enter Underlying Causa (Disaase or injury that initiated evants	c	0	,					t
death certificate e ettending physical	by Physician/Medic	resulting in death) Last		Due to	o (or as a conseq	juance or):				
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the ett	Sici	Part It. Other significant conditi	ons contributing to	death but not r	resulting in the u	nderlying causa	given in Part I.	23b. Dld to	bacco uae contri	outs to the cause of death
d by	Phy	MAKKYCCI	trike	lan	1 wor	c in his	Disense	1 □ Ye	es 22 No 3	Probably 4 Unknow
requires tha	d by							24a. Was ar	n autoney 2	4b. Wara autopsy findings
v require	leted	EVERL PINIS	hern/	MISCU	MARC	15+115	7	perform		available prior to comptation of causa
The lew ate hes b pege 2 s	Сотр	Tanel. 15	1	·	1. inch	actor.	us tehi	1□ Ye	es XXNo	of death?
VITAL The stellar: The certificate rector, per	Be C	25. Was case referred to madica	TTROSI	) - /	MIKAR	05101	26 Ptace of Dea	ath (Check only on		10 100 2010
	To B	examiner? 1 ☐ Yas 2 ☑ Vo	Hospitat:	Inpatient 2	ER/Outpatier	nt 3 DOA	Othar: 4 Nursing H		ence 6 Other	Specify)
Jing Phys After this funeral d		27. Mannar of Death		e of Injury onth, Day Year,	28b. Time o	f 28c. Ir	njury at Nork?		ow injury occurred	
Attending or death.	catio		igation				☐ Yes 2☐No			
LIVISION of a transport of a tree death.  I Director: After to by the funeral of in by the funeral of the funer	Certification:	4 Homicide determ	nined 200. Plac	ce of fnjury - A Iding, etc. (Spe	t home, farm, str ecify)	reet, factory, offic	Ce	City or Town	reet and Number on, Stata)	or Rural Route Number,
spital nours neral		29a. Certifier	ng Physician: To th	ne best of my k	knowledge, deat	occurred at the	e time, date and place	, and due to tha ca	ause(s) and mann	er as stated.
To the Hospital or / within 24 hours after To the Funeral Director Completely filled in b.	edical	(Check only 2 medical	Examiner: On tha	basis of axam	ination and/or th	vastigation, in m	y opinion, daath occu	rred at the time, da	ate and place, and	dua to tha cause(s)
withi To th	Σ	29b. Signatura and title of certific	ar /	. //	7	29c. Lica	ansa number	2:	9d. Data signed (A	fonth, Day, Year)
50		Hell	11/11	ill	111	D13	818		12/29/	1998
		30. Name and address of person	who completed car		tam 23a) (Type,		O BETHESDA	A. MARYI.A	AND 20815	
S	tate	31. Data filad (Month, Day, Year		Registrar's Sig	gnature &		4 - 4	-,		
Regis		DEC 3 1	1998	perer	P.	space				



State of Maryland / Department of Health and Mental Hygiene

							(	Certifica		Death		Reg. N	30		293
	Physic	ian	1. Decedent'e Nama (First, A	liddle, Las	1)						2. Date of Do		ey Ya	ar	3. Time of Death
	/Medi		Denton Webber	E11:	iott						Decemb				6:20pm
	Examir		4a. Facility Name (If not instit	ution, give	street and numi	ber)				4b. City, Town, or	Location of Dee	th 4	c. County of D	Deeth	
			Wilson Health	Care	e Center					Gaithers	burg	N	lontgom	erv	
	Funeral		5. Social Security Number	6. Se		. Age (In yrs	last birthe	day) If Unde Months	r 1 Yeer	If Under 24 Hrs	6. Dete of Bi	rth	9.		ace (State or Foreign
	Director		269-10-2344 Usual Residence of Deceder		M 2□F	84	Yr	s.	Days	7 TOUTS   IVIIII	Feb. 1	3, 1	914	Ohi	
	and w		10a. Stete 10b. Co			10c. C	ity, Town o	or Location						10	Od. Inside City Limits
	/anyl	ŏ	V 7 1 1 W												1 ŽŽYes 2 □ No
	the the	Director	Maryland Mo	atgom	ery	l Ga	itne	rsburg 101. Zi	n Code			100.0	Itizen of Wha	Count	nn ()
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Box	death certifica e attending ph id for use as th	Physician/N													
0	0 0 2	yslo	Part II. Other significant con	ditione co	ntributing to dea	th but not res	sulting In th	ne underlying	cause gh	ven in Pert I.	23b. Did	tobaco	o uee contrit	bute to	the cause of death?
9	requires that the de been signed by the a hould be detached	P.	Lecentar	wi	teme	Joza	ede	al L	rex	laul	con 10	Yee	2 No 3	Prob	ably 4 Unknown
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Ö	Attending ir deeth. ector: After by the fune	atlo	E C Mooiderit	estigation		-u,,	111,0	M		Yes 2□No					
Division	Atte ecto by th	tific		uld not be ermined	26e. Pleca o	I Injury - At h	ome, farm	, street, fector	y, office		28f. Location City or To			r Rura	Route Number,
ō	o and and and and and and and and and and	Certification:	T D TIOMICIO		Dullding	, etc. (Speci	'Y/				Oily or 10	WII, OIA	1107		
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	To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: All completely filled in by the fu	edical	(Check only 2 Med one)	cai Exami	ner: On the bes end manne	is of examina or steted.	ation end/o	or Investigation	, in my o	opinion, death occi	urred at the time	, date a	nd place, end	due to	the cause(s)
	within 2 To the comple	×	29b. Signature and title of ca	tifier				/29	c. Licens	se number		29d. D	ate signed (N	Aonth, l	Day, Year)
	25		Hel	rke	its	isi	lel	anda.	11	204	15	De	cemo	her	25. 199
	1		30. Name and address of per	son who o	ompleted cause	ol death (ite	n 23a) (Tv	pe, Print	~						
			H. Robert Bir					1	Blvc	l., Bethe	sda. MD	208	317		
	Sta		31. Date liled (Month, Day, Y	ear)	32. Peg	gistrer's Sign		. /		4	, -22				
	Registr		DEC 2	3 199	8	never	10	. 10	all						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 4 2 Certificate of Death 2 Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey Month JUDITH ENGEL DEC 25 1998 10:20AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) 8208 RESERVIOR RD FULTON HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 XF Yrs. 126 34 2177 63 HUNGARY Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits HOWARD 1 ☐ Yes 2 No **FULTON** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8208 RESERVIOR RD 20759 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes TO No WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 SECRETARY SELF EMPLOYED 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) GRUNWALD PAULINE SCHWARTZ LASZLO 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8208 RESERVIOR RD, FULTON, MD 20759 TIBOR ENGEL HUSBAND JOEL 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State
4 Donetton 5 Other (Specify) MT. LEBANON CEMETERY 12-27-98 ADELPHI, MD Signature of Fun val Ser ice Li Ins 22. Neme end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 23a. Pen . Enter the 1st see, of confinctions that cau led the death. Do not enter the mode of dynd, such as cardiac off-espiratory and structure. List only one cause on each line. Interval Between Onset end Deeth Immediat Ceuse (Fin I disease or addition resulting in death CANCER YEARS METASTATIC LUNG Due to (or es a consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1□Yes 2VNo 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medicai Examiner

Examiner

**Physician** 

/Medical

Examiner

MD

Directo

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at

pemit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mental thygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumetic event, the Medical Example

Baltimore, Maryland 21215-0020

deeth with the Merylend

ed by the attending physician and detached for use es the buriel-transit signed b should I has certificate this

funeral After

27. Manner of Death

1 Neturel

2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

(Check only

The law requires that the death certificete be executed Box 68760 Physician/Medical P.O. þ Completed Physician: Be To Certification: or Attanding death. Director: / after edical

To the Hospital o within 24 hours aft to the Funeral DI completely filled in 8

State Registrar 29b. Signature and title of cartifier Meitin a

5 Pending investigation

6 Could not be

MALTIA C. SHARGEL

31. Dete filed (Month, Dey, Year)
DEC 29

28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number D08944

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end menner stated.

1 Yes 2 No

29d. Dete signed (Month, Day, Year)

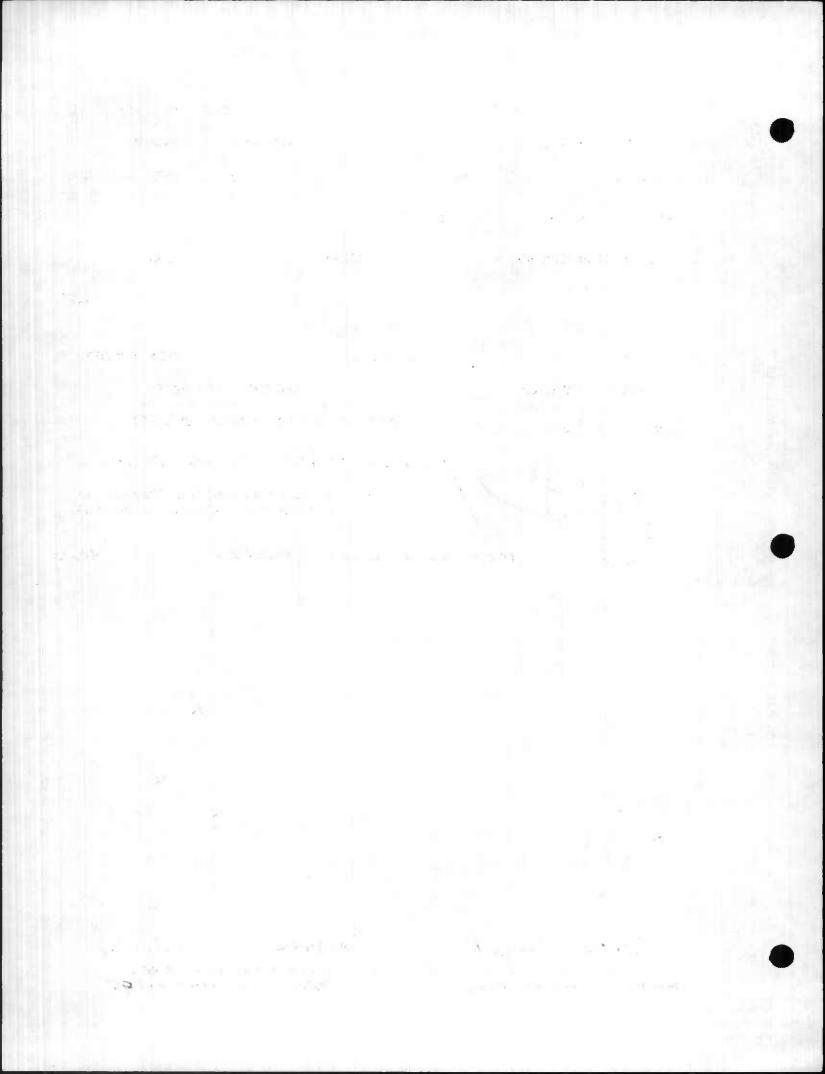
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

3720 FARRAGUT AUE KENSINGTON, MD- 20895

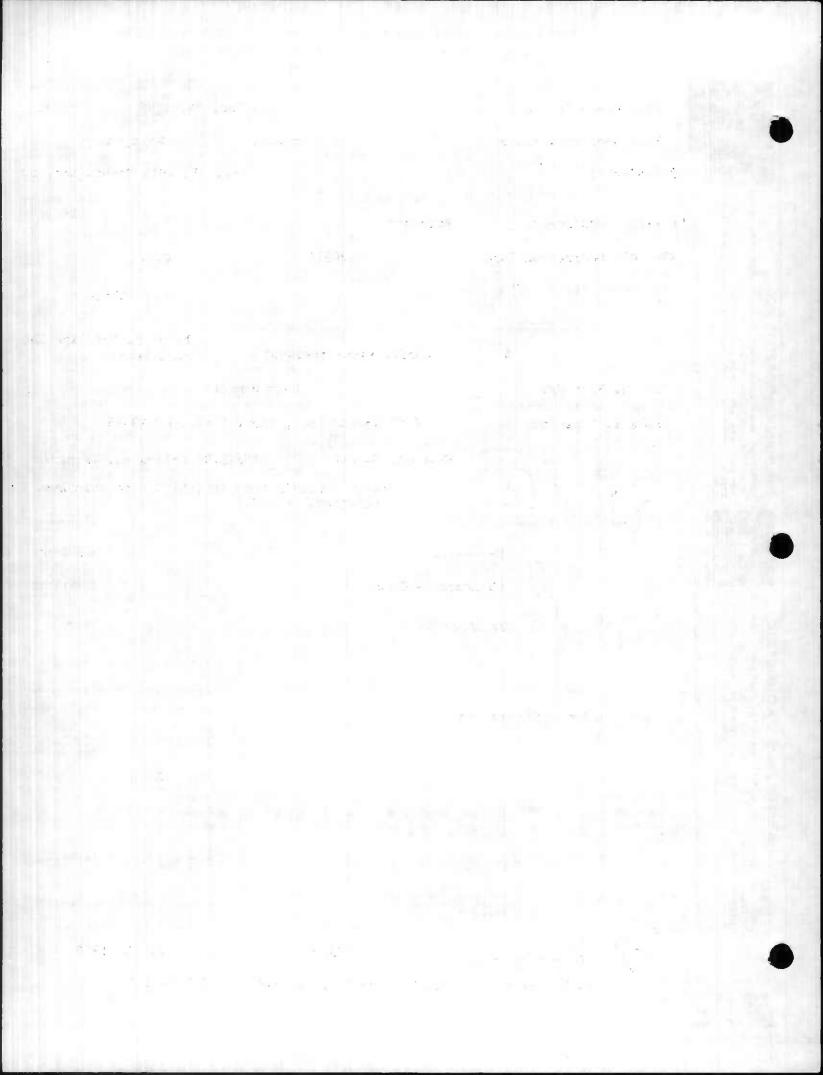
28d. Describe how injury occurred

C.Y 32. Registrer's Signeture



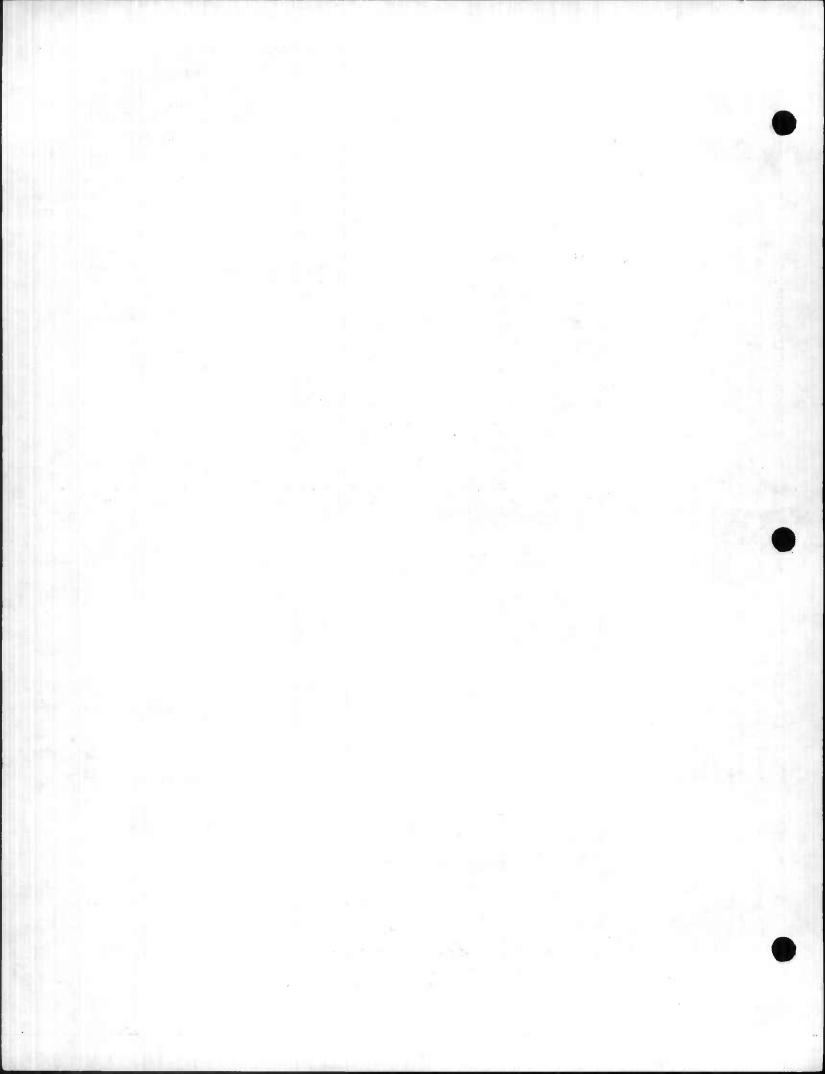
State of Maryland / Department of Health and Mental Hygiene 8 4 295

	4 December 10 Name (First Middle)	ont)		Cen	tificat	e of	Death	2. Data of Dea	Reg. No.	-	3. Tima of Death
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Examiner		The second second second					Bethesda				
	Maplewood Parl  5. Social Security Number 6.		a (In vrs I	ast birthday)	If Under	1 Yaar	If Undar 24 Hrs.			gome 9 Birthr	
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ehow of all	10a. Steta 10b. County		10c. City	, Town or Loc	ation				75040	1	0d. Inside City Limits 1 🗓 Yas 2 □ No
vith the Ma t or 28a-1 e be nottled Director	Maryland Montgor	nery	Bet	hesda							
or 2	10e. Street and Number				10f. Zip	Code			10g. Citizen of W	Vhat Cour	ntry?
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	James E. Farr-						Dr., Che				
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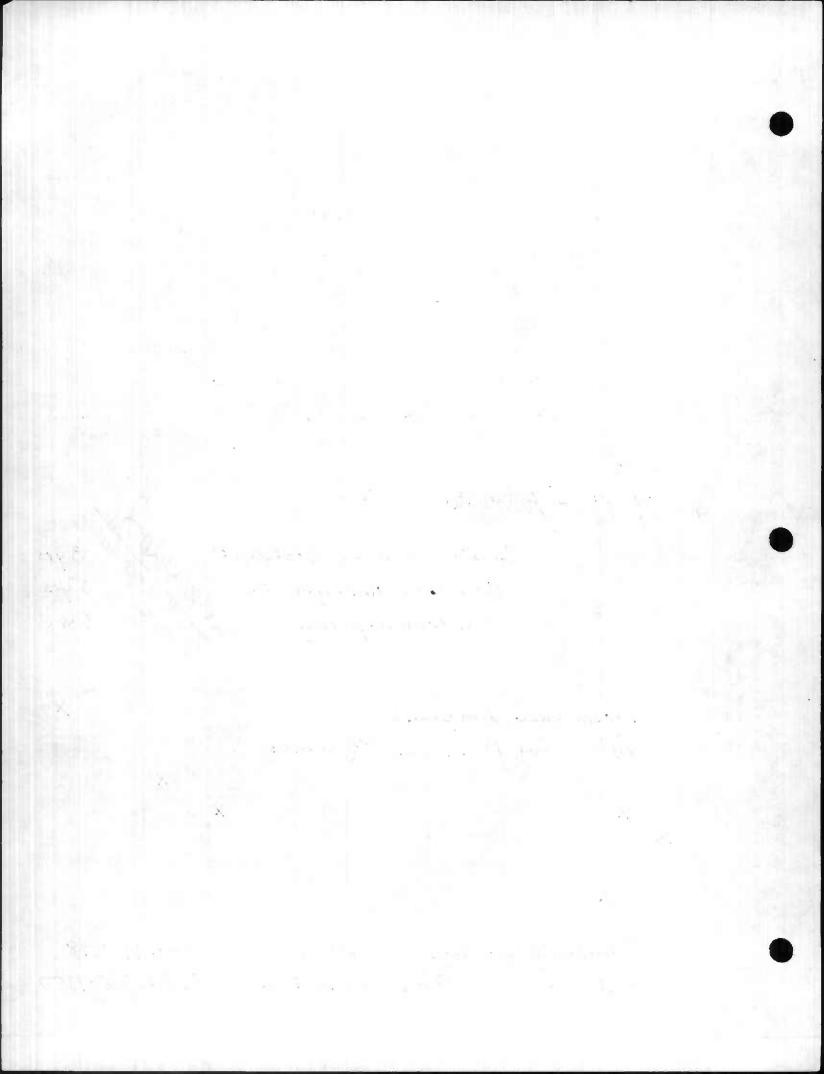
State of Maryland / Department of Health and Mental Hygiene 9 4 296

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/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)				4b. City, Town	n, or Location of	Death	4c. County	of Death	
Examine	Holy Cross Hospit	al				Silver	Spring		Montg	omerv	
Funeral	5. Social Security Number 6. S		e (In yrs. last birth			If Under 24	Hrs. 8. Date	of Birth	J	9. Birthplace	State or Foreign
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	23a. Part1. Enter the disease, or com	plications that caused	the death. Do no	t enter the m	JIST ode of dv	Avenue	, Silve	r Spr	ing,	. An	proximete
	23a. Part1. Enter the disease, or com shock, or heart feilure. List only	one cause on each li	ne.		,			,		Int	erval Between
hysician /Medical	Immediate Cours /Final										
xaminer	Immediate Cause (Final disease or condition resulting in death)	Pneumon	nia							1 1	week
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een signed b hould be dete hould by PI							24a.	Wes an a		24b. Were	autopsy findings ble prior to
should should been s							_	performe	ar	compl of dea	etion of cause
has 70 2									K		
Com						100	2.76	1 Yes	2/Q No	1 O Y	as 2 No
s certificate director, pag To Be Co	25. Was case referred to medical examiner?					26. Place o	of Deeth (Check	only one)			
8 D	1 Yes 2₽ No	Hospital: 1 Inpatie	ent 2 ER/Outp	atient 30	OOA O	ther: 4 Nurs	ing Home 5 🗆	Residenc	e 6 □Oth	er (Specify)	
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rs efter death. al Director: After tied in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Plece of Inj building, et	ury - At home, fem c. (Specify)	ı, street, fect	ory, office			tion (Street or Town, S		per or Rural Re	oute Number,
within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	(Check only 2 Medicat Exan	ysician: To the best niner: On the basis o	examination and/								
within 2 To the complain	one)	and manner of	ate6.								
	29b. Signature and title of certifier	NY	1	2	9C. Licer	se number				d (Month, Day	r, Year)
3	11/mon C	X den	Alex	/	200	0674		De	ec 24	11998	
	30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print)							
	MYRDN 1	IFNIKIN	~ mp		9 Sh	orefiel	d Rd Si	lver	Sprin	o MD 2	0902
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State	DEC 2 8 10	00 /2	we L	7. 1	2001	21					



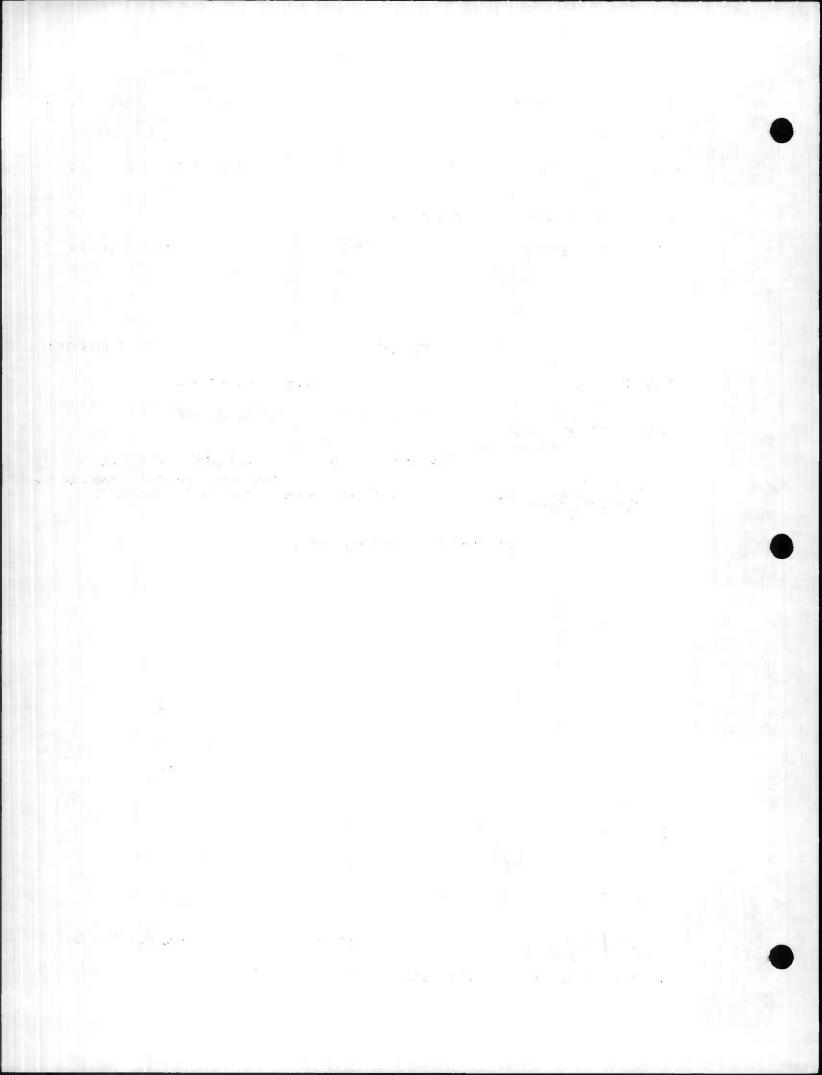
State of Maryland / Department of Health and Mental Hygiene Q [ 1 2 0 7]

				C	ertificate	e of	Death			Reg. No.	) 7	(m o/ 1
	Dhusisian	1. Decedent's Name (First, Middle, L							2. Date of De	ath	-Yeak	3. Time of Death
Ę.,	Physician /Medical	Douglas A.	Fields						Decembe		1 <sup>4</sup> 9 <sup>4</sup> 98	10:00 A.M
	Examiner	4a Facility Neme (If not institution, gr 6904 Wells Park				U	Jniver	sity	Park		ty of Death ce Ge	orges
	Funeral Director	216-12-4561	Sex 7. Age (In yrs	6 Yrs	Months	1 Yaar Deys	If Under 2 Hours		8. Dete of Bir (Month, Da Feb. 28	th by, Year) 3, 1922	9. Birthp Cour Care	olace (Stete or Foreign olina
pue	ž	Usual Residence of Decedent  10a. State 10b. County	10c. C	ty, Town o	r Location						1	Od. Inside City Limits
he Mary	or 28a-f ah be routhed Director	MD Prince	Georges		Univer		y Par	k				1 ☐ Yas 2X No
death with the Maryland		10e. Street and Number 6904 Wells P	arkway		10f. Zip		782			10g. Citizen of	What Cour USA	itry?
21215-0020 d within 72 hours efter dea	by F		12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No 11 Yes, Give Year or Dates: 1943		13. Wes Decede If Yas, speci			gin? (Spe , Puarto F	cify Yas or No Rican, atc.)	Spec	eck, White,	
5-0 72 ho	ygiene. er then "neturn t, me Medical Completed	15. Decedent's E		18a. De	ecedent's Usuel	Occup	oation during most	of working	na	16b. Kind of	Business/Inc	dustry
121	mple.	Elementery/Secondary (0-12)	College (1-4or 5+)		live kind of work to. DO NOT use Lck Deal		d)			Automo	hilo	
			,	Dul	ick bear	rer	18 Mothe	r's Name	/First Middle	Maiden Suma		
and	ed out	Thomas M	cCoy Fields							McCall		
Maryland	th and Men 7 is marke traumatic	19a. Informent's Neme/Relationship	(Type, Print) elds/ Wife		Melling Address							
nore,	or other	20a. Method of Disposition  1 Derial 2000 Cramation 3	Removal from State	cemetery,	isposition (Nem cremetory or of	her ple		D	Dete ec 19,	20c. Location		
Baltimore	Separtmen mportant: any injury and injury	4 □ Donation 5 □ Other (Spec 21. Signature Funeral Service Lice	'37	-	22. Nama end Inc. 5	Addra		1	ncis J Blvd.	. Colli	ns Fu Silve	neral Home r Spring,
		J. Pleur	Mousin		MD, 209	901				(	7.1	
	ysician Medical	23a. Pert1. Inter the disease, or con shoot or heart reilure. List online immediate Cause (Fine)								nest,		Approximate Interval Between Onset and Death
Ex	aminer គ	disease or condition resulting in deeth)	a. Cerebro Due to ( b. Cardi	or es e cor	nsequence of):		-	ide	ne	X07	NE OF	5 413
petn	in and iol-transit Examiner		b. Cardi	ac	nsequence of):	he	Ihn	ro'a	1	WYA		Jyrs
9,0		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	0				1	1	11/10	(BY A	/	1 Vac
68760	physician s the burie edical E	that mitiated events	c. Dua to (c	or es a con	ny opense of):	110	27		10	LIMINO		1 413
	Wed the	resulting in death) Lest							pay	with the		
Box death cert			d					t	APP	•		
	sici	Part II. Other significant conditions	contributing to deeth but not re-	sulting in th	e underlying ca	use giv	ven in Pert I.		-	tobacco uas c	ontribute to	o the cause of death?
P.O.	igned by the attendibe detached for use	Pacema	ker Imp	lan	t			11	10	Yea 2□ No	3 Pro	bebly 4 Unknown
of Vital Records, Physician: The law requires t	been s should	Extens	ine Press	en	e u	low	und	5		en autopsy ormed?	av	ere autopsy findings railable prior to empletion of cause death?
H H	certificate has rector, page 2 Be Comp		( VECUBITOU	s ul	CERS)				10	Ves 2 No	10	☐Yes 2☐No
a ë	ertifica ector, p	25. Was case referred to medical					26. Place	of Death	(Check only o		1	
of Vita Physician:	his certification of the direction of th	examiner?	Hospital: 1 Inpatient 2	ER/Outpa	atient 3 DO	A Oth	ner: 4 Nu	rsing Hon	ne 5 Rasi	dence 8 □O	ther (Specif	<b>y</b> )
VISION O	22 00	27, Menner of Death  1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Tim Inju	e of 28	Bc. Injui Wo	ryat rk? IYes 2 □ f		28d. Describe	how injury occ	bernu	
Division or Attending	Director Jin by th	3 Suicida 6 Could not l 4 Homicide determined		ome, ferm	, street, factory,	office		2	28f. Location (. City or To		nber or Rura	al Routa Number,
To the Hospital	Within 24 hours ared deem. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one) (Check one) (Che	nysician: To the best of my kno miner: On the basis of examine and mannar stated.	owledge, detion end/o	eeth occurred e r investigation,	t the tin	me, dete end opinion, deet	d place, a th occurre	and due to the ed at the time,	cause(s) and r date and place	nanner as s o, and dua to	tated. o the cause(s)
o the	No the	29b. Signeture and title of certifier	4		29c.	Licens	se number			29d. Data sign	ed (Month,	Day, Year)
	4	Fam 1.1.	Jones Home		Î	)3	0111			Der.	19 1	998
12		30. Name and address of person who	completed cause of deeth (Item	m 23a) (Ty	pe, Print) 0. te pa	7)	- Re	Ha	sile 1	Ud 2	1700	998
	State	31. Dete tiled (Month, Dey, Year)	32. Registrer's Sign	ature			0	V100		1000	, ,,,,	110/
	Registrar	DEC 28 19	98 Jeneva	B	· ppo	uk.						



State of Maryland / Department of Health and Mental Hygiene 8 4 298

					C	ertificat	e of	Death			Reg. No.			
Physician /Medical		me (First, Middle, La (KARL) FORS								2. Dete of De Month DECEMBI	ER 27,	1998		of Deeth
* Examiner	4a Fecility Name HERREW H	(If not institution, giv IOME	e street end num	ber)				b. City, To		ocation of Deat		Inty of Death		
Funeral Director	5. Sociel Security 086-16-0	527	Sex MM 2□ F	Age (In yrs 87		Months	Days	if Under Hours	24 Hrs. Min.	8. Date of Bir	th Y5 <sup>a</sup> r) 1	911 Sinth	place (Ster	te or Foreign
vith the Menyland to or 28a-f show be notified at Director	10a. State	10b. County  MONTGOMI	ERY		ity, Town or	Е								City Limits
th with the 23e or 2 and be not all Direct and Direct a		AAITTE COI	JRT			10f. Zij	852				10g. Citizen	of What Cou TED ST		
within 72 hours after death with the Meryland ene. Then "netures", or tems 23s or 28s-f show the Medical Examinar must be notified at ompleted by Funeral Director.	Widowed	rrled 2 Merried 4 Divorced	12. Wes Deced Armed Ford Arthyes if Yes, Give Yeer or De	es?		3. Wes Dece If Yes, spe 1 \(\superscript{\text{Yes}}\)	cify Cub	lispenic Orl an, Mexicer Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Rece - Ameri Bieck, White ocity:		le
ed within 72 hours at ygiene. wer than "natural", or it, the Medical Exami Completed by F	(Spe	15. Decedent's E	ade completed)		16a. De	cedent's Usu ive kind of wo a. DO NOT u	al Occup ork done	ation during mos	t of work	ring	16b. Kind o	f Business/Ir	dustry	
ed withing of the man to the man	Elementary/Sec		College (1-	4or 5+)		RITOR					GARMEN		FACT	JRING
2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Manaumatic evant, the Man	17. Father's Name	(First, Middle, Last DRSETER								e (First, Middle		reme)		
2 9 9 5		Name/Relationship (	Type, Print)							NS NY 1		wn, Stete, Zi	p Code)	
Ta lead	1 🗆 Burial 2	FORSETER sposition Cremation 5 Other (Special	Removal from S	tate	cemetery, c	sposition (Ne remetory or	other ple			Dete		on - City or T		
permit. Pages Department of P Important: If its any injury or of		uneral Service Licer	nsee	,,LI		22. Name e	nd Addre	ss of Facili	DAN:	ZANSKY- E ROCKV	GOLDBE	RG MEM	ORTAI	L CHAPI
Physician /Medical Examiner	Immediate Cause disease or conditi resulting in deeth)	on	PARKI.		1112	ENTIA		PLEX			-		Onset ar	nd Death
certificate be executed rights and use as the buriel-transit		onditions, mmediate lerlying r injury	b			sequence of)						1		
ling ing	resulting in deeth)	Last	d											
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aw aw										24e. Wes	en eutopsy ormed?	8:	Vere autop vailable pri ompletion f death?	sy findings ior to of cause
F # a O										+0		5 1	☐ Yes 2	2□ No
Physician: this certific ral director,	25. Was case reference examiner?	rred to medical No	Hospital:	patient 2	] ER/Outpa	tient 3 D	OA Oth			th <i>(Check only</i> ome 5□Resi		Other (Spec	ify)	
6 6- E	27. Manner of Dee r ☐ Natural 2 ☐ Accident	oth 5 ☐ Pending Investigatio	28a. Date of (Month		28b. Time Injur		28c. Injui Wo	yat rk? Yes 2 □		28d. Describe			,	
To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	3 Suicide 4 Homicide	6 ☐ Could not b determined	28e. Piece (	of tnjury - At t g, etc. <i>(Spec</i>	nome, ferm, ify)	street, factor	y, office			28f. Location ( City or To	Street and N wn, Stete)	umber or Rui	ral Route ∧	lumber,
he Hospit in 24 houn he Funera pletely fille	29a. Certifier (Check only one)	XX Certifying Ph 2 Medical Exam	nysician: To the base niner: On the base and manner	is of examin	owledge, de ation and/or	ath occurred investigation	at the ti	ne, date an pinion, des	nd place, ath occur	and due to the red at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the caus	se(s)
To the within to the comp.	29b. Signeture	d title of pertifier	1: D.				c. Licens L 8084	e number			29d. Date si DECEME			_
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State	31. Date filed (Mo			estrer's Sign		9. 1	oou							



					Ce	rtificate d	of Dea	atn			ı. No.		1 500	
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/sician ledical	Rosa	May	Fra	ınk					1	ember		1998	1:05	a.m.
aminer	4a Facility Name	(If not institution	n, give street and n	number)			4b. Ci	ity, Town, o	or Location	of Death	4c. County	y of Death		
	Suburbar	n Hospit	tal				Bet	hesd	а		Montg	gomery	,	
eral	5. Social Security	Number	6. Sex		rs. last birthday)	If Under 1 You Months Da		Jnder 24 H	in. 8. Da	te of Birth onth, Day, Yo	(ear)	9. Birthp	lace (State	or Foreign
tor	053-18-9		1□M 2反F	78	Yrs.				Jan	. 11,	1920	Washi	Ington	, DC
	Usual Residence	-		140-	Oh. T							La		Mr. 0.1 W
rector	MD	Montag			City, Town or Lo							1	Od. Inside C	2 No
Funeral Director		Montgo	omery	CII	evy Chas	1								200140
- E	10e. Street and N	lumber				10f. Zip Coo	le				. Citizen of		try?	
Ta La	4701 Wil	llard Av	venue			20815					J.S.A.			
- Pu	11. Marital Status		12. Was De Armed F	ecedent Ever in Forces?	n U,S. 13.	Waa Decedent If Yes, specify (	of Hispan Luban, Me	nic Origin? exican, Pu	(Specify Young	es or No- etc.)		ce - America		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rried 2 Marr	If Yes G	s 2⊠No Give		1 ☐ Yes 2 ፟፟፟		ecify:			Specif	w. Wh	ite	
d by	3 LXWidowed	4 Divorced	Year or	Detes:										
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Be	17. Fether's Nemo		LASI)							, Middle, Ma	uden Sumai	me)		
2	Norman 1							Agnes						
	19a. Informant's	Name/Relations	ship (Type, Print)		19b. Meili	ng Address (Str	reet and h	Number or	Rural Rout	te Number, C	City or Town	, State, Zip	Code)	
	Milton		Son	,	5801	Edson 1	Lane	T-4						
	20a. Method of Di		3 Removal from	m State 7.1	b. Place of Dispo cemetery, crei ashingt	sition (Name o matory or other	place)		Date		c. Location			
		5 Other (S		C	ashingto Congrega	on Hebr	ew		110/0	1 /00 T	Jachin	oton.	D.C.	
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To Be Completed by Physician/Medical Examiner	23a. Per 1. Intushuck, r hi Immediate Cause diaease or condit resulting in death  Sequentially list of any, leeding to cause. Enter Uncause (Diaease or that initiated ever resulting in death  Part II. Other algorithms of the cause of the c	e (Finel tion )  conditions, Immediate deriving or Injury nts )  Last  erred to medical	complications thet only one cause on a. ANE b. CAF c. ISC d. Co	Consequence of the consequence o	ENCEPH o (or as a consect C CAR I o (or as e consect resulting in the u	2. Name and Accept G. W., Waster the mode of ALO PATIQuence of): Quence of): Q	meter dress of a which is hing dying, sure the control of the cont	Facility  T S S  S T O I ,  ch as card	Death (Che g Home 5	Inc. 5 20016 iratory arrest  3b. Did toba 1 Yes  4a. Was an a performe 1 Yes ck only one) 5 Residence	acco usa co s 2 No autopsy ad?	ontributa to 3 Prot	Approximation of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause	te threen Death  YS  WWW  of death?  Unknown  findings to cause
Be Completed by Physician/Medical Examiner	23a. Per 1. Interpretation of the shock of t	(Finel tion )  conditions, immediate derlying or injury nts in the condition of the conditi	b. CAff c. ISC d. Co hose contributing to the	Due to Du	ENCEPH o (or as a consect C CAR I o (or as e consect resulting in the u	2. Name and Accept G. W., Waster the mode of ALO PAT quence of): Q	meter dress of awler shing dying, su NY	Facility  T S S  S TON,  Sch as card  Pert I.	Death (Che g Home 5	Inc. 5 20016 iratory arrest  3b. Did toba 1 Yes  4a. Was an a performe	acco usa co s 2 No autopsy ad?	ontributa to 3 Prot	Approximation of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause obey 4 property of the cause	te threen Death  YS  WWW  of death?  Unknown  findings to cause

Rosa may Frank Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year) 29c. License number DECEMBER 29, 1998 A. Sirderson, MD 19144

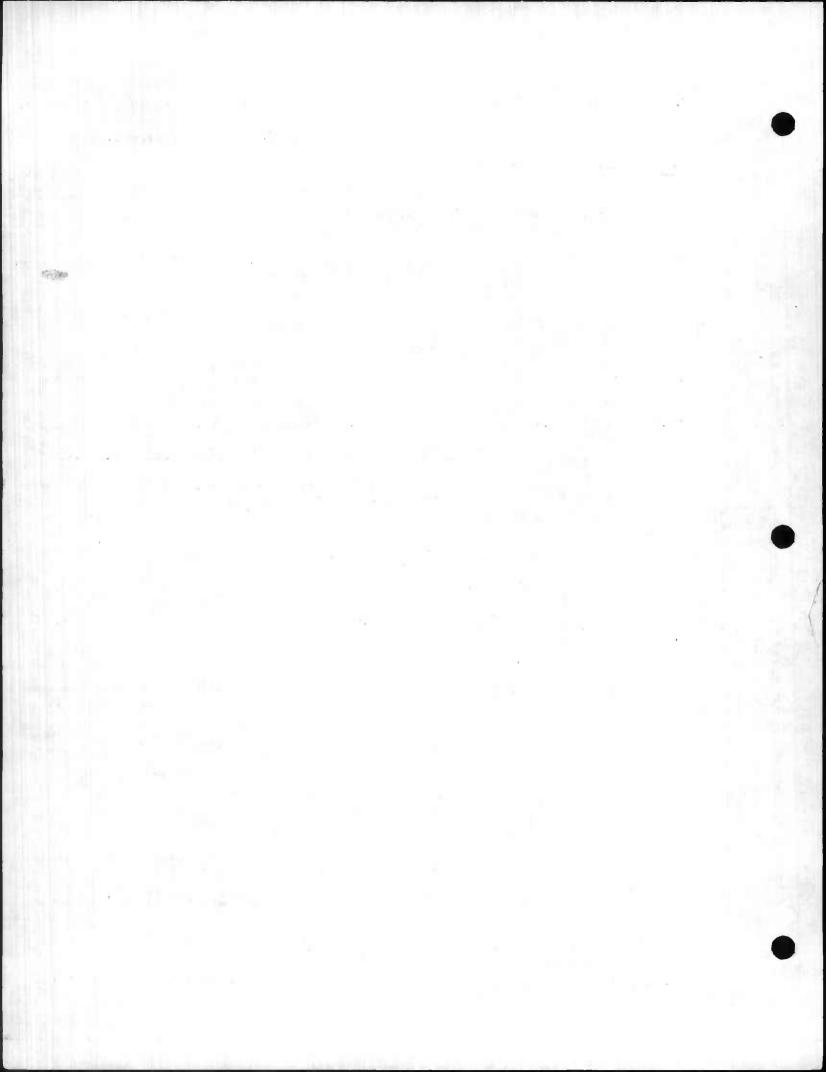
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS G. SINDERSON, MD. GHID ROCKLEDGE

DRIVE,

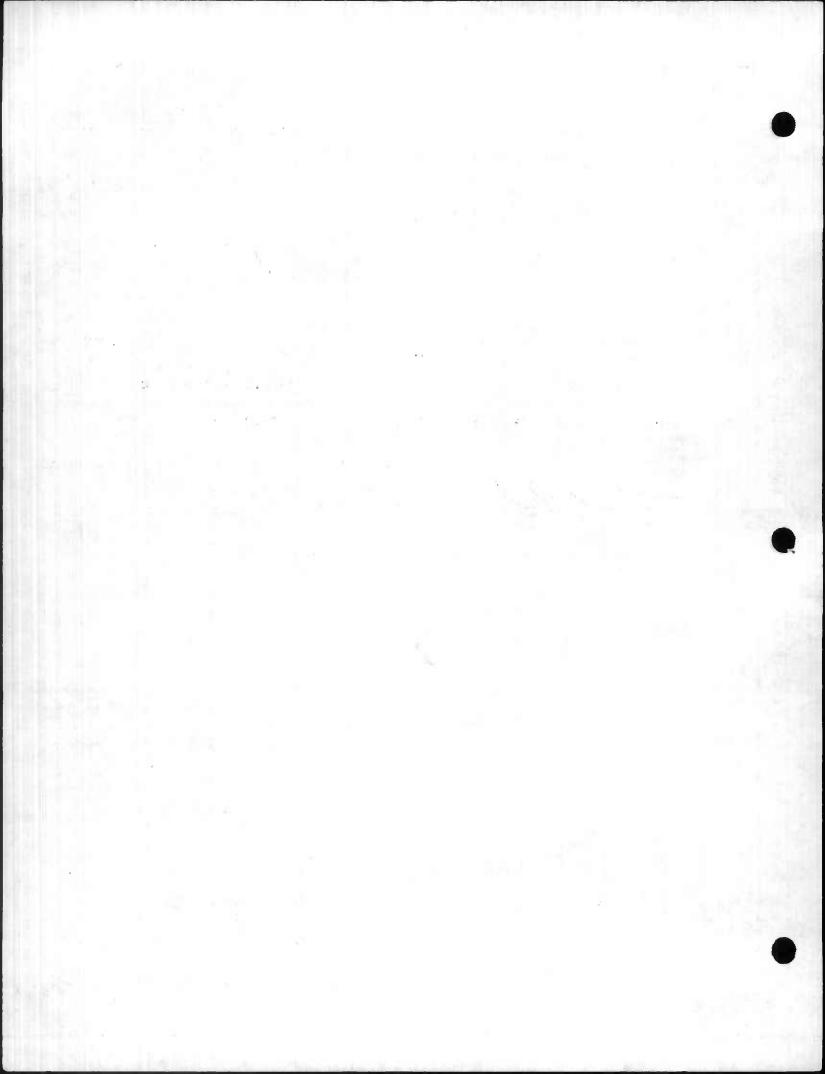
BETHES DA, Md. 20817

State Registrar

12-29-98 105 Am



Physician	PART I, 27 PER MEO G76  1. Decedent's Nema (First, Middle, Las  Donnell J Free	et)	2. Deta of Death Month Dey Vear DECEMBER 21, 1998								
/Medical Examiner	4e Fecility Neme (If not institution, give 4729 JOHN STREET		Location of Deat	th 4c. County		ES					
al, or fishing 23s or 28s-f show Estimates routed by notified at by Funeral Director	3/9-/4-4464	OM ADE	46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bit	-1952	9. Birthplace (S Country) Wash D	ete or Foreign		
	Usuat Rasidence of Decedant  10a. Steta 10b. County  MD P.G.		ity, Town or Local						de City Limits		
	10e. Street and Number	30			10g. Citizen of \						
	4729 John Stre  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1XD Yaa 2 DNo If Yes, Give DCYenva Patas Guar	11	2074 as Decedent of H Yes, specify Cub ☐ Yes 2 🗓 No	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	Blac	lace - American Indian, clack, White, etc.			
other than "natural", rent, the Medical Ex-	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation	16a. Decede (Give k life. De	nit's Usual Occup ind of work done O NOT use retire Super	during most of wo d) Visor		Sidley Law Fi				
To Be	17. Father's Neme (First, Middle, Last) Haywood Freem	an	lame (First, Middle, Maiden Sumame) ine M. Waldron								
	19a. Informant's Name/Relationship (7		1	and the same of the same of		Rural Route Number, City or Town, Stele, Zip Code)					
6	20a. Method of Disposition	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)									
any injury or o	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Austin Royster Funeral Home 3821 14th St. NW Wash, D.C. 20011										
ifor use as the burial-transit clan/Medical Examiner	Cause (Disease or injury that initiated events that initiated events the property of the prope										
by me tached	Part II. Other eignificant conditions co	ontributing to death but not re-	sulting in the unc	derlying cause giv	ven in Part I.	ntributa to the ca	use of death?				
2 should be d						24a. Wes	Yea 2 No	24b. Were auto available; completio of death?	ppsy findings		
s certificate ha director, page To Be Com	25. Wes case referred to medicei	26. Place of Death (Check only one)									
E = -	27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year)	28c. Inju			ome Describe how injury occurred					
al Director: After tied in by the funera Certification:	3 Sulcide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, stree ify)	et, fectory, office			(Street and Number or Rural Route Number, wm, State)				
To the Funeral Dir completaly filled in Medical Ceri	29a. Certifier (Check only one)	rsician: To the best of my known of the basis of examine and menner stated.	owledge, death of entire entir	occurred at the tie estigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma , date and place,	anner as stated. and due to the ca	use(s)		
M M	29b. Signature and title of certifier	2. Chute, no		c.M.E.		29d. Data signed (Month, Day, Year) DECEMBER 22, 1998					
State Registrar	TO	32. Registrar'e Sign	1 Penn S	rint)	Baltimor	e, Maryl					

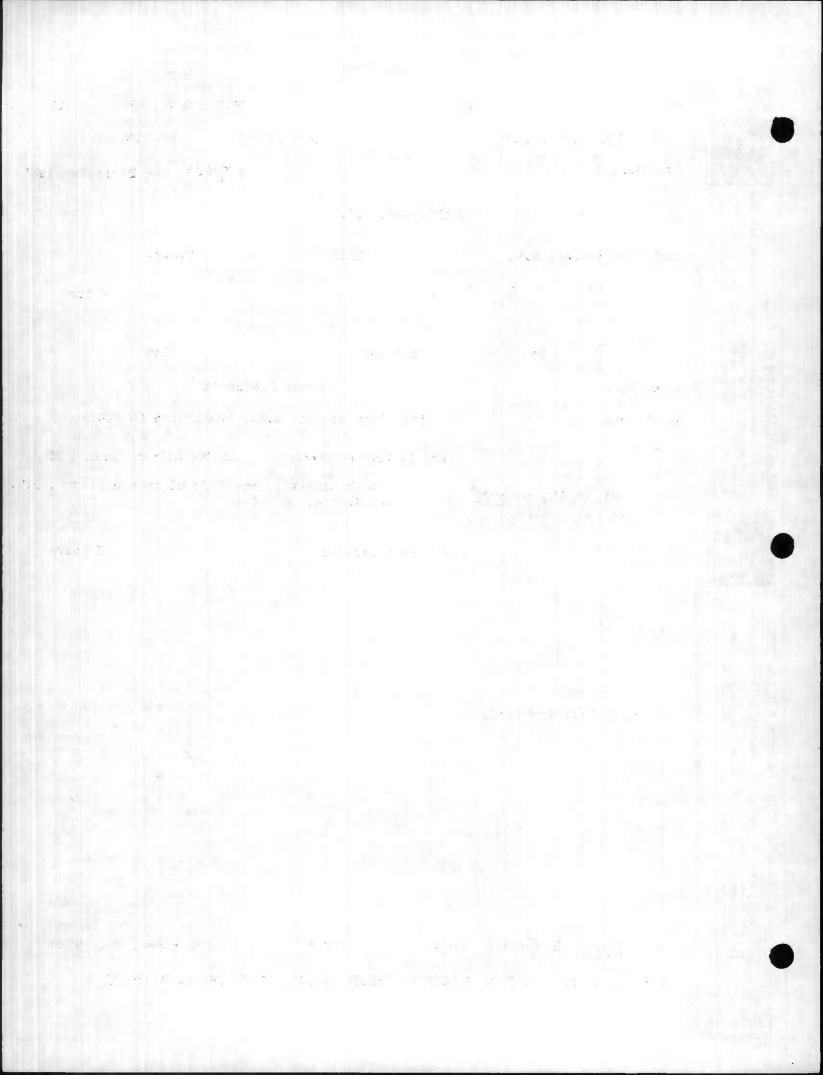


State of Maryland / Department of Health and Mental Hygiene 8

					C	ertifica	ate of	Death		Reg. No.				
Physician		1. Decedent's Name (First, Middle, Last)							eath Day	Day Year				
/Medical	DAVID FUSS								DECEMB		1998	11:55 P.1		
Examiner	4a Facility Name MANOR C.		4b. City, Town, or I											
Funeral Director		5. Social Security Number 6. Sec. 577-54-8857					der 1 Year ns Days		8. Date of Bi (Month, D AUGUST	rth ey, Year) 5,1911				
	Usual Residence	-		100 0	h. Taum	or Location						and Incide City Limite		
23a or 28a-f ahow at be notified at al Director	N/A	N/A				on, D	.C.					13 Yes 2 No		
be notified Director	10e. Street and	Number				10f.	Zip Code			10g. Citizen of What Country?				
a le	5412 318	st Street,	N.W.	N.W. 20015			0015			U.S.A.				
by Funer		s arried 2⊠ Married d 4 Divorced	Armed Fo	12. Was Decedent Ever in U,S. Armed Forces?  1 ⅓ Yes 2 ☐ No			cedent of P pecify Cub 25 No	Hispanic Origin? (Sean, Mexicen, Puert Specify:	pecify Yes or N o Rican, etc.)	o- 14.	rican Indian, o, etc. Vhite			
rt, tre Medical Exe Completed by		15. Decedent's E pecify only highest gr	ade completed)	e completed) (Give			suai Occup work done r use retire	pation during most of world)	king	16b. Kind of Business/Indus				
om o	Elementery/Se	econdery (0-12)	7+	College (1-4or 5+)						Law				
Be C	17. Father's Nan	ne (First, Middle, Las		2100			18. Mother's Nam			, Meiden Sui	meme)	)		
To B	Jacob Fr	uss						Dora Rab	inovit	novit				
traumen	19a. informent's	Name/Reletionship	Type, Print)					(Street and Number or Rurel Route Number, City or Town, State, Zip Code) Street, N.W., Washington DC 20015						
importaint, it team 27 to marked other than any Injury or other traumetic event, the Monce.  To Be Comp										er Spring, MD				
eny inju	1	Fundal Service Lice Plah	1. Pete	10)		Jose;	oh Ga ingto	n. DC 200	016		onsin .	Avenue, N.		
	23a. Part1. Ent shock, of	the disease, or con eert feilure. List only	plications that one cause on e	ceused the dea each line.	th. Do no	t enter the m	node of dyi	ing, such as cerdia	or respiratory	errest,	1	Approximate Interval Between Onset and Death		
sician edical miner	Immediate Cause (Final disease or condition a. Alzheimers Disease resulting in death)										3 years			
iner	Due to (or as e consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.													
edical Examiner														
Z 62	thet initiated ever resulting in deat	erits -	Due to (or as a consequenca of):  d.											
Physician/	Part fl. Other sig	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributions									contributa	to the cause of death		
deteched for use	Cereb	ral Vascul	ar Acci	dent					10	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown				
cate has been signed; page 2 should be de Completed by P								Ш	24a. Wa	s an autopsy formed?	8	Were autopsy findings available prior to completion of ceuse of deeth?		
page 2									1□	Yes 25th		1 ☐ Yes 2 ☐ No		
rector, pag		ferred to medical	26. Place of Death (Check only one)											
0 D	examiner?	⊠ No	Hospital:	doenitel: Other						4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)				
After th funeral	27. Manner of D  1 2 Natural 2 Acciden	5 Pending	28a. Date (Mon	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Injury a Work?  M 1 □ Year					28d. Describe					
od in by the f	3 ☐ Suicide 4 ☐ Homicio								28f. Location City or To	ocation (Street end Number or Rural Route Number, City or Town, State)				
To the Funeral Director: After the completely filled in by the funeral completely filled in by the funeral Medical Certification:	29a. Certifler (Check only one)  1  Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause and manner stated.											stated. to the cause(s)		
To To M										29d. Date signed (Month, Dey, Year) December 26, 1998				
	30 Name and a	ddress of person who	completed caus	se of death /Ite	m 23a) /T	vne Print)								

State Registrar

ELLEN PINHOLT, M.D. 5530 WISCONSIN AVENUE, #1045, CHEVY CHASE, MD 20815

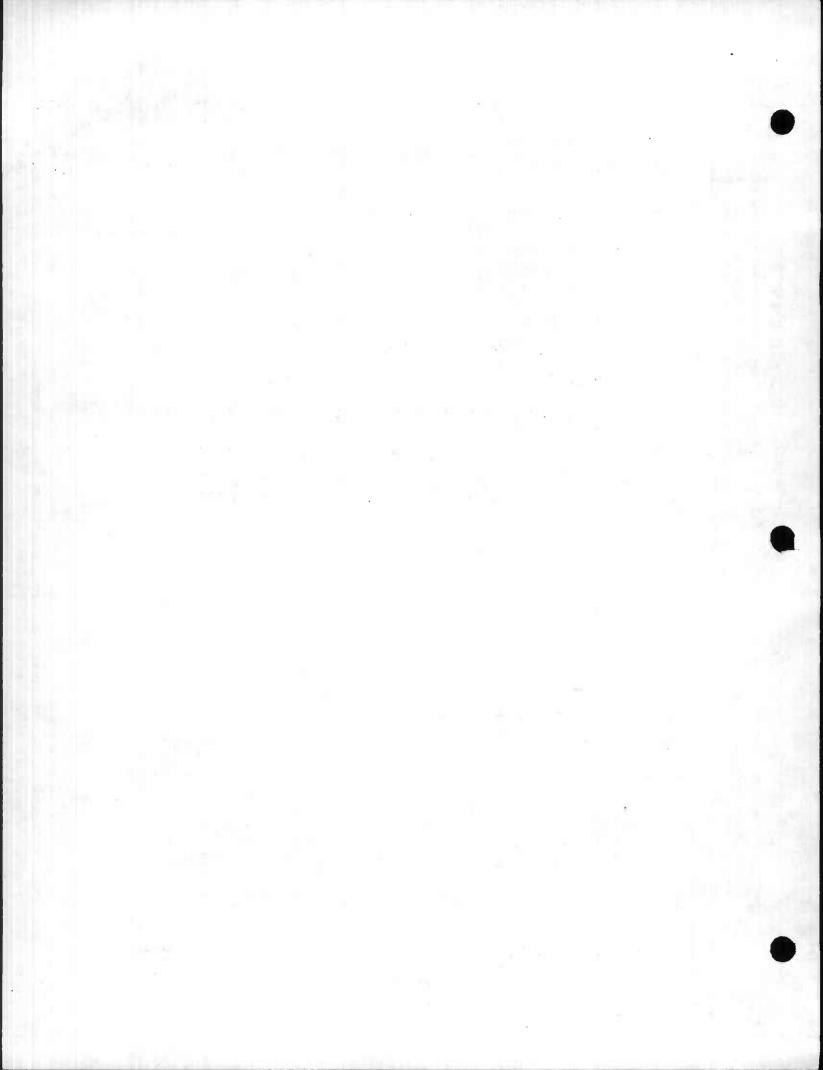


P.O. Box 68760,

that the deeth certificete be executed burial-transit ending physician r use as the burial ed by Records, been signe should be The law requires pege 2 director, peop of Vital Physician: this After Division Attending deeth. i or Attend efter deeth Director: / 3 To the Hospital of within 24 hours of To the Funeral D completely filled

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** December 18, 1998 K. 4:10PM ROBERT /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PERRY POLINI
If Under 24 Hrs.
Hours | Min. | 8. Date of Birth (Month, Day, Year) | Max. 20,1937 VA MARYLAND HEALTH CARE SYSTEM CECIL 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country)
S. Carolin 7. Aga (In vrs. last birthday) **Funeral** Days 18 M 2□ F Months 61 137-26-7782 Carolina Director Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits Rockville 1 Yes 2 No Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò U.S.A. 20853 rail, or hams 23a 14105 Gaines Avenue Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) ld be filed within 72 hours after de entel Hygiena. ked other than "natural", or fram ic evant, the Medical Exertinat Nas 2 No If Yas, Giva Year or Dates: 1 ☐ Nevar Marriad 2 ☑ Married Specify: Black 1 Yes 2 No Specify: b 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Microbiologist N.I.H. permit. Pages 1 and 2 should be file Department of Health end Mentel Hy, important: if them 27 is marked othe any injury or other traumatic evant, phose. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Corrine Mixson Hermna Ginn 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14105 Gaines Ave., Rockville, MD 20853 19a. Informant's Name/Relationship (Type, Print) (Wife) Baltimore, N Wilhelmina V. Ginn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 12/29/98 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22 NAME AND P.A. ROCKVILLE, MD 20850 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) PNEUMONIA 1 Day Examiner Dua to (or as a consequence of): Physician/Medical Examiner Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT, OLD. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy SEIZURE DISORDER. 1X Yes 2 No 1 ☐ Yes 2 1 No HYPERTENSION Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 42 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Describe how injury occurred 5 Panding invastigation 1 XNatural Injury 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only one) 29b. Signatyra and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) Jawsmy, M.D 151094-1 December 18, 1998 10 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND MELECIA SANTOS, M.D. 32. Registrar's Signatura State 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent'a Name (First, Middle, Last) 3. Time of Death DECEMBER 26, 1998 **Physician** HELEN GINSBURG 3:20 PM MOORE /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11901 JUBAL EARLY COURT MONTGOMERY POTOMAC If Under 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2ਊF Yrs. Director 026-22-3962 05-12-1929 69 Somerville, Mass with the Menyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas No Potomac Director Montgomery 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? I a marked other than "natural", or Itema 23a or Iraumatic event, the Medical Examiner must be 11901 Jubal Early Ct 20854 Funeral IISA deeth 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yaa or No-If Yaa, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelih and Mental Hygiene.
Important: If item 27 is marked other than "natural", or lier any injury or other traumatic event, the Medical Examines page. 1 Yes 2 No If Yas, Give Yaar or Datas: 1 Nevar Marriad 2 Marriad altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samue 1 Moore Frances Slobodkin 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 9120 Paddock Ln, Potomac, MD 20854 Martha Feis (Daughter) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Othar (Specify) 12-29-1998 Alexandria, VA Mt Comfort Crematory Signature of Runeral Se ce Lice 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. Ant1. Enter the disease, or communications that caused the deal? Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one ceuse on each line. Approximate Interval Between Onset and Daath **Physician** Immediate Cause (Final disaa o or condition resulting in the lin) /Medical Unknown Myocardial Infarction Patrisus L. Tomoko, mo Examiner Due to (or as a consequence of) Examiner the death certificate be executed physician and s the burial-transi Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 USB signed by the a d be detached f Part II. Other eignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown Diabetes Mellitis Type I by 24b. Were autopsy findings available prior to leted 24a. Was an autopsy performed? Hypertensive Cardiovascular Disease completion of cause of death? page 2 Comp TUYES 21 No Hypo Thyroidism 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 Rasidence 6 ☐ Other (Specify) 1X Yes 2 No omsko Inneral 28e. Date of Injury (Month, Day Year) 27 Manner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No 24 hours efter death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) MD D 38802 12-29-1998 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

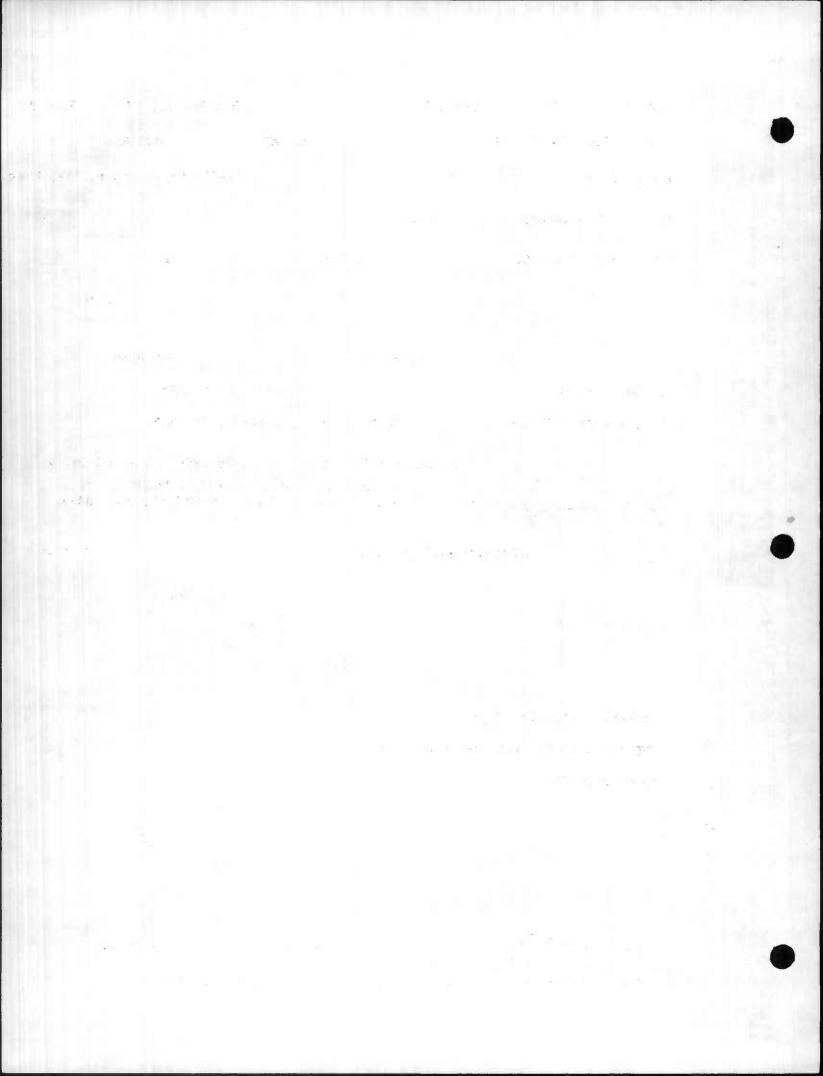
Registrar

31. Date filed (Month, Day, Year)

DEC 31

Osvaldo M. Gonzalez, MD 5530 Wisconsin Ave, Chevy Chase, MD 20815 32. Registrar's Signatura

parkel



				(	Certificat	te of	Death	7		Reg. No	D.			
1. Decedent's Neme	(First, Middle, La	st)		SUPE	2. Deta of Deeth Month Day Y			Year	3. Time of Deat					
Annette	e Heller			Dec.		1998 7:40		PM						
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To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Phys /Me Exa

Fune Direct

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hyglene. Important: If item 23 er merked other than "natural", or items 23e or 28e-4 show any fullury or other transmitter away, in a leading a large internal be notified as any fullury or other transmitter away.

**Physicia** /Medic Examin

Baltimore, Maryland 21215-0020

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of ceptifier 29c. License number

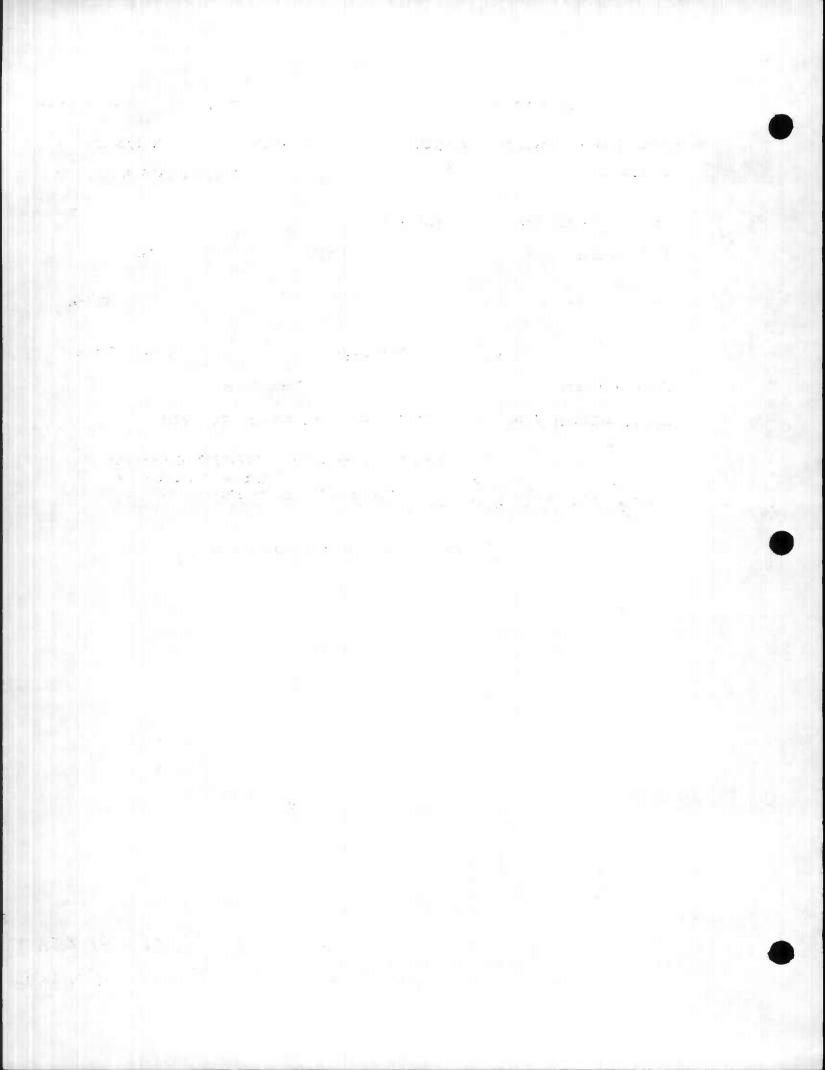
leted cause of death (Item 23e) (Type, Print)

30. Name and address of person who combined by a D. PATEL 6121 MONTROSE

31. Dete filed (Month, Dey, Year)
DEC 3 1

32. Registrer's Signetura

Medical Cer



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene DAVID Certificate of Death 27 PER MEO GOLDSTEIN ITEMS: #23 PART I 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day David S. Goldstein **DECEMBER 20,1998** 10:20A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 304 BELTON ROAD SILVER SPRING MONTGOMERY Hours Min. 8. Date of Birth 12.02.1950 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Yrs. 48 526.17.2562 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rait, or hems 23a or 28a-f ahor Examinar must be notified at Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 BELTON ROAD 20901 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Ham 27 is marked other than "natural", or her any injury or other traumatic avent, the Medical Exemples. 1 Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ②(No Specify Specify: WHITE p If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INVESTOR INDEPENDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN GOLDSTEIN ELIZABETH BELLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN H. WEISS/FRIEND 8211 POSTOAK ROAD, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/98 ADELPHI, MARYLAND MT. LEBANON CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC." 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part 1. Enter the diages of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical FATTY LIVER Examiner Due to (or as a consequence of): Examine be assecuted Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical The law requires that the death certificate Due to (or as a consequence of): 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown SCHIZOPHRENIA Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2□No 1 ☐ Yes 2 ☐ No of Vital Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 TResidence 6 Other (Specify) edical Certification: To TY Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After ! Division 5 Pending investigation 1 (2) Naturat 1 Yes 2 No death. the 1 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide 6 To the Hospital within 24 hours of To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Siggature and title of certifier O.C.M.E. **DECEMBER 21, 1998** 10 Mule

State Registrar 31. Data filed (Month, Day, Year) **DEC 28** 

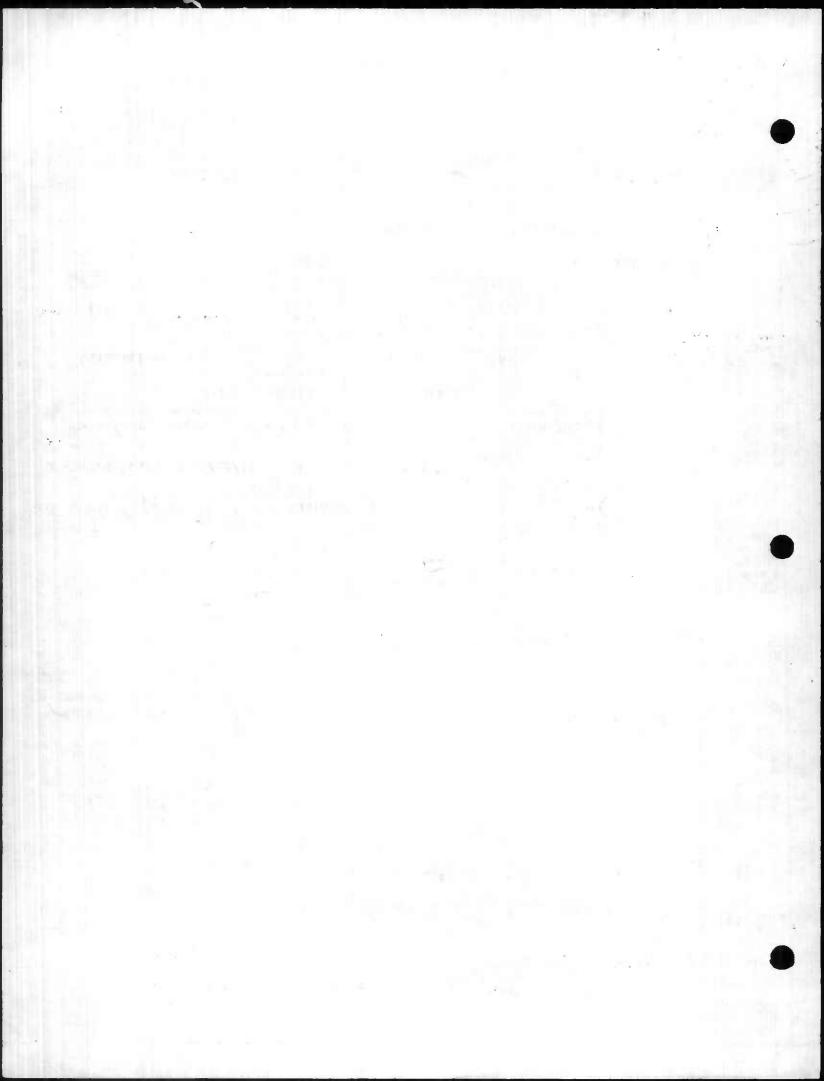
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3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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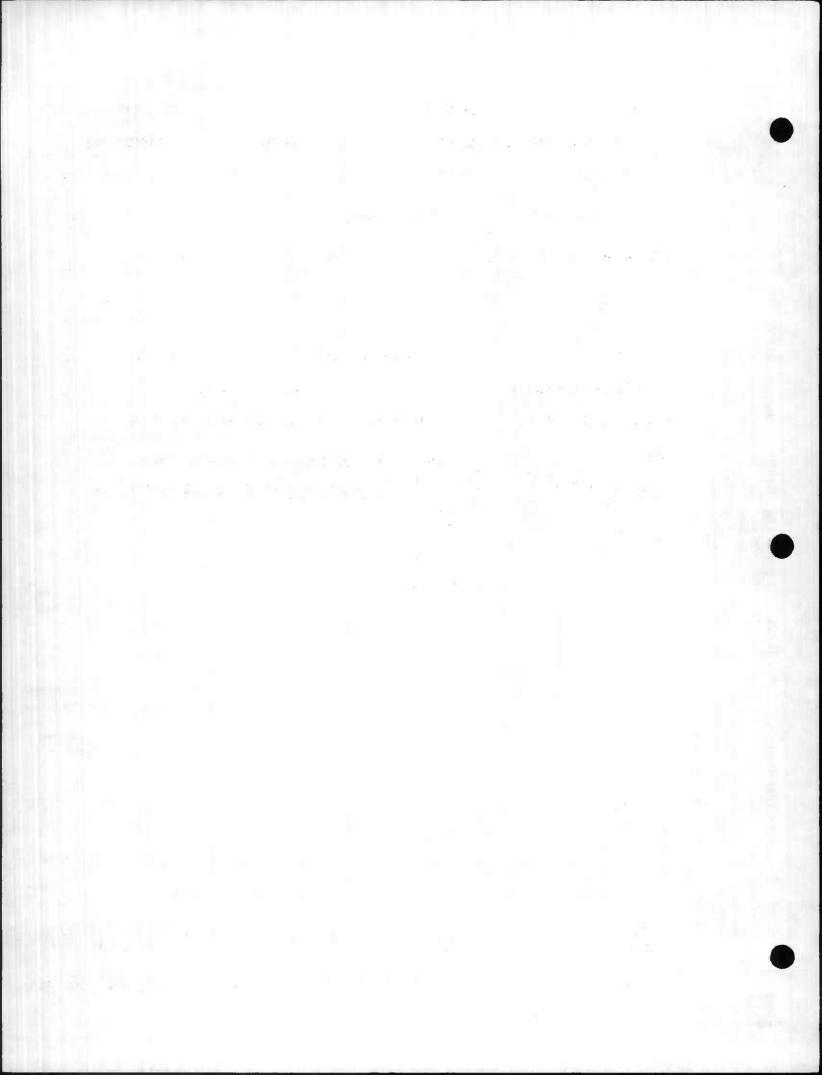
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111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 9 8 4 3 0 6

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State of Maryland / Department of Health and Mental Hygiene 8

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	Holy Cross Ho	spital				100	Silve	r St	ring	Mont	gomer	v			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi (Month, D		~	place (State or Forei	ign		
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Funeral Director		9-66-		Sex 1□M 232 F	7. Age (In yrs		Moni	der 1 Ye		Under 2	4 Hrs. Min.	8. Date of (Month, June	Birth Day, Yes 21 1	913	Cou	place (State or Foreign ntry) nada
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certificate has b rector, page 2 s		e casa rata	red to medicel						200	P. Diago	of Doot	1 th (Check on	☐ Yes	2 <b>X</b> No	1	☐ Yes 2☐ No
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after deatl Director: 3 in by the ertifical		] Homicide	determined	289. Plac	ce of Injury - At I ding, etc. (Spec	home, farm cify)	, streei, fac	tory, off	ice			281. Locatio City or	n (Street Town, St	and Num ate)	oer or Rui	rai Houte Number,

To the Hospital or Attending Physicien: The la within 24 hours after death.

The Funeral Director: After this certificate her completely filled in by the funeral director, page 2 Comp Be Certification: To

28e. Place of Injury - At home, farm, streei, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

Dec. 23, 1998

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. inetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ceus of death (Item 23a) (Type, Print) 30. Name and address of person who compile Mark H. Eig MD.

10801 Lockwood Dr. #280 Silver Spring, MD 20901-1563

D 24886

State Registrar

Medical

31. Date flied (Month, Day, Yeer)
DEC 3 0

32. Registrar's Signature

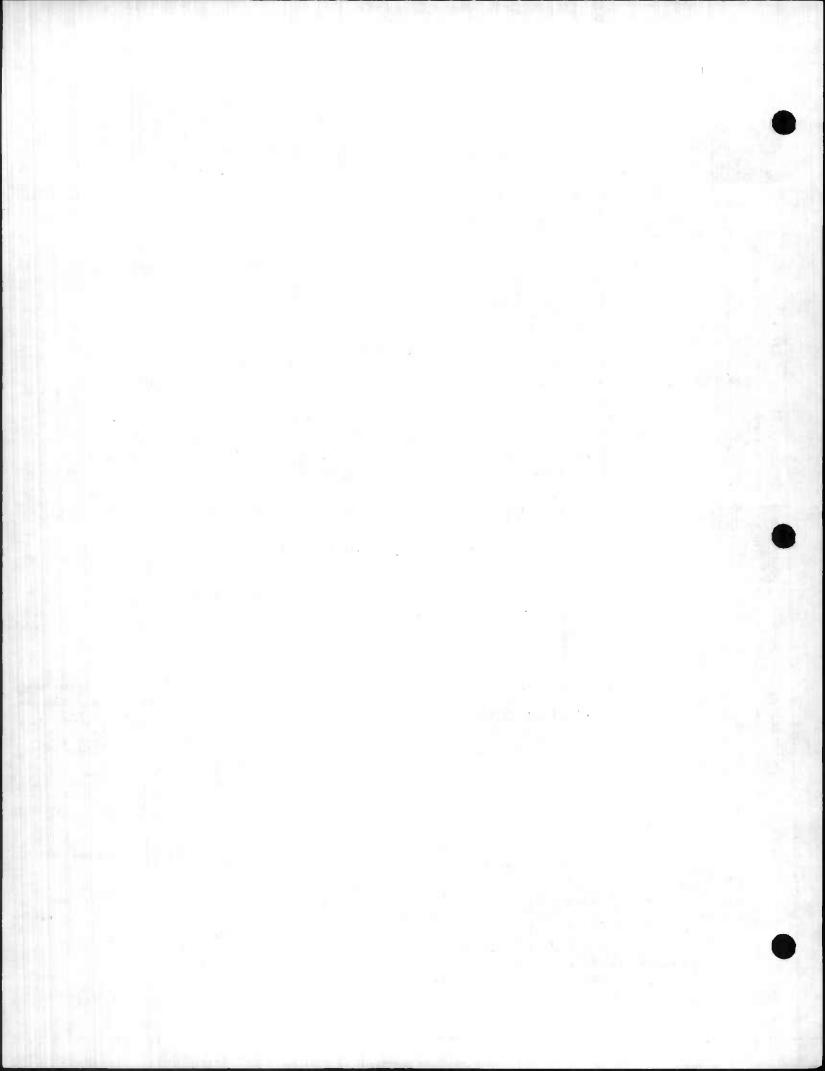
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 1 3 9

			C	ertificat	e of	Death		Reg. No.	•		
	1. Decedent's Name (First, Middle, L.	est)					2. Date of D Month	eath Day	Year	3. Tima of D	eath
Physician /Medical	Carma Marrial	Gibbs						er 27, 1		11:32	PM
Examiner	An English Name /M not institution of	ve street and number)			4	b. City, Town, or	Location of Dea	th 4c. County	of Death		
	Suburban Hospit	al al				Bethesd	а	Mont	gome:	rv	
Funeral		Sex 7. Age	(In yrs. last birthda	// If Under Months	7 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of B			place (State or I	Foreign
Director	274-10-6144	1UM 201F (	38 Yrs.		5.,0			9, 1910		hio	
2 .	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	anation	-					Od Inelde City	Limite
aly a house										1 ☐ Yes 2	
vith the Me or 28e-f a be notified Director	Maryland Montgo	nery	Bethesda		0.4			40. 000	100		A
Die Por				10f. Zip				10g. Citizen of V			
20 seter death with the Menylar or items 23a or 28s-1 show aniner must be notified at	7402 MacKenzie	12. Was Decedent E	unc in II C 12		0817	ispanic Origin? (S	inacihi Vae or N	United		es Indien,	
Per d	1 Never Married 2 Married	Armed Forces?	- The Late of the	If Yes, spec	city Cuba	in, Mexican, Puer	to Rican, etc.)	Bled	ck, White,		
15-0020 72 hours eft "natural", or ulos Essas	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□ Yes	2)() No	Specify:		Specify	. Whi	te	
D S Poor	15. Decedent's E		16a. Dec	edent's Usua	al Occup	ation	_	16b, Kind of Br	usiness/in	dustry	
1 21215-0 led within 72 hot typiens. her than "naturn nt, the Westerl	(Specify only highest gr	ade completed)	(Gin	DO NOT us	ork done o	during most of world)	rking				
Signal Paris	Elementary/Secondary (0-12)	College (1-4or 5+		cretar	cy			Doctor	s Of	fice	
De file dother went,	17. Fether's Name (First, Middle, Las	)				18. Mother's Nar	me (First, Middle	, Maiden Suman	10)		
Baitimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effect death with the Meryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show and hipty or other traumatic event, the Medical Franche must be notified at and.  To Be Completed by Funeral Director		gan				Mayjel	Almyra	Woodrufi	E		
Short Short	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address	s (Street	and Number or Ru	ural Route Numi	ber, City or Town,	State, Zip	Code)	
M mith	Jerilyn K. Gibbs	(daughter	r) 7402	MacKe	enzie	Court,	Betheso	la, Mary	land	20817	
OF THE STATE OF TH	20a. Method of Disposition	water to be a first	20b. Place of Dis	position (Nar	me of	a)	Date	20c. Location -	City or To	own, Stete	
Pages Nent of I	1 Burial 2 Cremetion 3 (		Chesape			14	12-29-98	Beltsvil	lle,	Marylan	ıd
Baiti Permit. Departm Importa any Inju	21. Signature of Funeral Service Lice	nsee	-			al Servi	oos P				
B Populario	1 0000	100				venue, S			larv1	and 209	10
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused t	-					-	IGI ) I	Approximata Intervel Between	
Physician	shock, or heart failure. List only	one cause on each line	).						1	Onset and De	en ath
/Medical	Immediate Cause (Finel	Mesenter	ric Arter	v Tnen	iffic	riency			1	1 week	
Examiner	disease or condition resulting in death)	a	Que to (or as a cons			Lency			1	1 "0010	
<u> </u>		ASVD	roe to (or as a cons	equence on.						10 year	S
: 68760, rificate be sweated ng physician and es the burial-transit	Sequentially list conditions	b	ue to (or es e cons	equence of):							
Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Hyperlip								20 year	S
cords, P.O. Box 68760, requires that the death certificate be swacuted over signed by the ettending physician and should be detached for use as the burial-transteed by Physician/Medical Exami	Cause (Disease or injury that initiated events resulting in death) Last	C	ue to (or as a cons	equence of):							
Med refler		. 7 - 40							1		
Box eath cer ettendir for use		d									
P.O. BOX at the death certi d by the ettending stached for use Physician/M	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying c	cause giv	en in Pert I.	23b. Did	l tobacco use co	ntribute t	o the cause of	death
Phys.	Costrointostinol	Uomorrhoo					10	Yes 2 No	3 Pro	bably 4 Kur	nknow
bed by	- Cas CI O ZII C C S CI I I I I	nemorrnage	-		-						
If Records, P.O. Boy The law requires that the death or zate has been signed by the ettend page 2 should be detached for us. Completed by Physician/	THE STATE OF THE S						24a. We per	s en eutopsy formed?	av	ere autopsy fine allable prior to	
D 2 2 0										empletion of cau death?	150
							10	Yes 2 No	11	Yes 2 N	0
Vital Ricelan The Loadillector, page						26. Place of De	ath (Check only	one)	-		
	1 Yes 2√ No	Hospital: 1 XInpatien	t 2 ER/Outpati	ent 3 DC	Oth Oth	er: 4 Nursing H	lome 5□Res	idence 6 Oth	er (Speci	(y)	
- a		28a. Date of Injury (Month, Day	Year) 28b. Time	of 2	28c. Injur Wor	y at k?	28d. Describe	how injury occur	red		
Attending or death. Attending by the fune iffication	2 Accident investigation	n		М		Yes 2□No					
DIVISION C bal or Attending P that death. al Director: Attert led in by the funeral Certification:	3 Suicide 6 Could not to determined		y - At home, ferm, ( (Specify)	street, fectory	y, office		28f. Location City or To	(Street and Numbown, State)	ber or Run	al Route Numbe	91,
Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely illied in by the fur Medical Certification											
n 24 hound no 24 h	29a. Certifier 1 Corulying Pl	nysician. To the best of miner: On the basis of a	my knowledge, del	investigation	at the tin	ne, date and place	, and due to the	date and place	anner as s	nated.	
the H the F the F		and manner state	ed.				7100 81 1110 11110				
Total E	29b. Signature and title of certifie			290	c. Licens	e number		29d. Date signe	d (Month,	Day, Year)	
In	MINIM	bara avs		D	3261	.0		December	28,	1998	
Y	30. Name and address of person who						-	0001-			
	T.J McNamara, M			rive,	Beth	esda, Ma	ryland	20817			
State	31. Date filed (Month, Day, Year)	32. Registrar		/	,						
Registrar		TUNE TOWN	Market My	- 1							

12-27-58

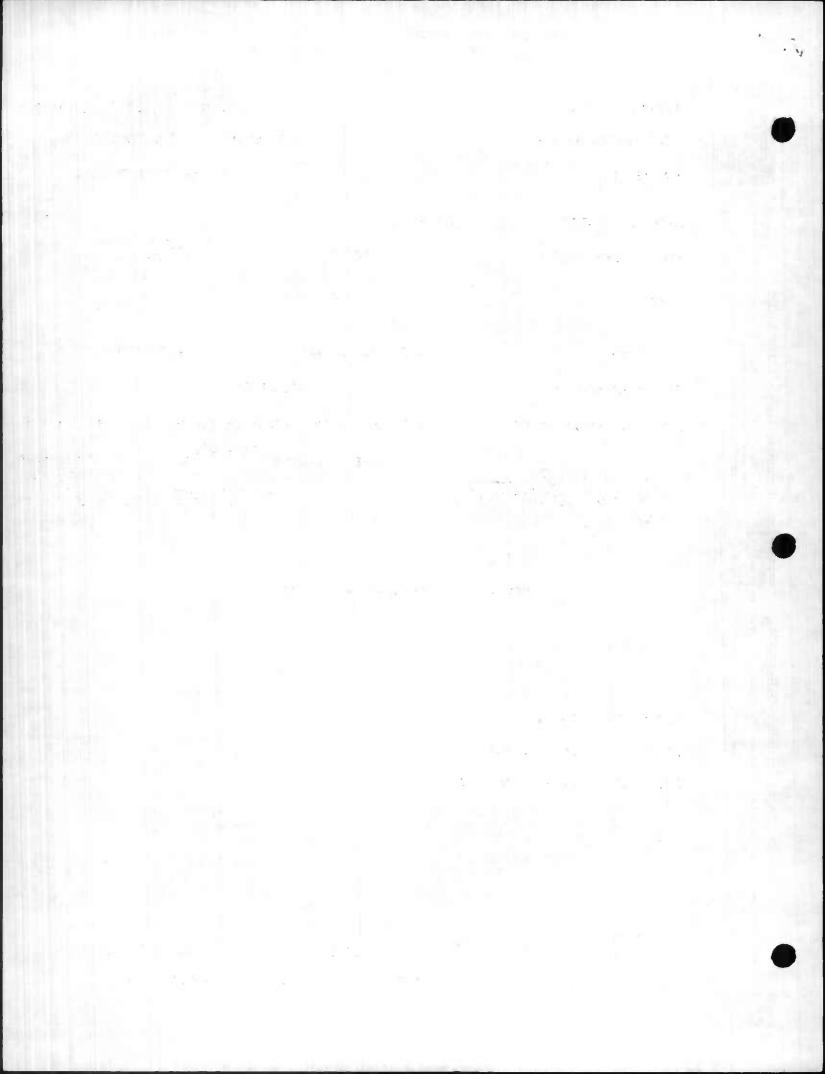


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State of Maryland / Department of Health and Mental Hygiene 2

							tificate of	Death		Reg. No.		-7 1	010	
	Physicia		1. Decedent's Nama (First, Middla, Las	t)					2. Data of De Month	Day		Yaar	3. Tima of D	eath
	/Medica		HERMAN E. HENN						DECEMB		1, 1	998	10:15	P.M.
	Examine		4a Facility Nama (If not Institution, giva	street and number)				4b. City, Town, or Lo	ocation of Deat		County			
			2307 PARKER AVENU	E				SILVER SE	PRING	MO	ONTG	OMERY		
	Funeral Director		578-03-8122	X 7. Ag XM 2□ F	a (In yrs. last b	Yrs.	If Under 1 Year Months Days		8. Data of Bir (Month, De NOV • 0	rth ay, Year) 05, 1	908	9. Birthple Countr GERMA	ca (Stata or I y) NY	Foreign
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	anyta ahow		10a. Stata 10b. County									100	1 Yas 3	
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	# 6 # F		10e. Street and Number				10f. Zip Coda			10g Citi	ED S	hat Countr TATES	y?	
	₩ th		2307 PARKER AVENUE				20902			OF A				
	dead .	Funeral	11. Marital Status	12. Was Decedant Armed Forcas?	Evar In U,S.	13. W	as Decedani of	Hispanic Origin? (Sp Jan, Maxican, Puarto	ecify Yas or No Rican, atc.)	0-		- Amarican		
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7	d wil	0	12th		A	UTO I	BODY REP	AIR		AUT	romo:	IVE		
2	should be filed within nd Mental Hygiene. marked other than imatic event, to a M	De C	17. Fathar's Nama (First, Middia, Last)					18. Mother's Nam	a (First, Middle	, Ma <i>id</i> an	Sumam	a)		
0	Alenti rked tice		KARL MARTIN HENN					LUISE EG	OLF					
di	2 should and Men is marks aumatic		19a. Informant's Name/Raiationship (T	ype, Pnint)	19	9b. Mailing	g Addrass (Straa	t and Number or Rur	al Routa Numb	ber, City o	or Town,	Stata, Zip C	Code)	
Ξ			ELLEN H. MURRAY (N	ITECE)	3	10 KI	NOLL CRE	EK CIRCLE	CHATTA	ANOOG	A TE	INNESS	SEE 374	415
, u	s 1 and f Health item 27 other tr		20a. Mathod of Disposition		20b. Place	of Dispos	sition (Nama of atory or other pla		Data			City or Tow		
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	/Medical Examiner		immediata Cause (Finei disaasa or condition rasulting in daath)	a UREMIA										
			rasulting in daath)		Due to (or es	a consequ	uenca ot):					i		
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00/00	lificate be executed g physician and as the burial-transit	Ca	that initiated evants rasulting in death) Last	G	Dua to (or as a	a consequ	ience ot):							
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	dead fo	200	Part II. Other significant conditions co	ntributing to death b	ut not rasulting	in tha un	darlying causa g	ivan in Part I.	23b. Dld	lobacco	use cor	tribute to	the cause of	death?
	t the by the tach								102	Yes 2	□ No	3 Probe	ably 4 🗆 U	Inknown
,	be de	Dy	CARCINOMA OF COLOR	V										
oras,	The law requires that the death certained has been signed by the attending page 2 should be detached for use	2							24a. Wes	s an auto	psy	24b. Wes	e autopsy fin lable prior to	dings
3	w requ	ef	CONGESTIVE HEART	FAILURE					peri	omear		0011	pletion of ca	use
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0	ficate or. pa		ARTERIOSCLEROSIS—0 25. Was case referred to medical	GENERALIZI	ED			00 81-11-15		-	12010	, ,,	103 201	10
5	certi	200	examiner?	Hospital:			0	28. Place of Deal		-	. Dow	(0/4)		
5	Attending Physician: or death. ector: After this certific by the funeral director.	0	1 ☐ Yes 2√TNo 27. Mannar of Death		nt 2 ER/0	. Tima of	3LI DOA	4 Li Nursing no	28d. Describe					
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2	or Al	Certific	4 ☐ Homicida datarminad	bullding, at	c. (Specify)	ianii, Stre	iat, lactory, office		City or To	wn, State	B)	or or riarar	1100101101110	01,
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			JOHN B. UMHAU, M.I			CICUT	AVENUE	CHEVY CHA	SE MARY	YLANI	208	315		
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	Registra	r	DEC 2 9 19	98 134		1.	popou	w						

DHMH 16 Rev 6/95



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** FLOYD 24, 1998 Н. DEC. 4:00 PM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner HOWARD 9311 All Saints Road Laurel If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthpiece (State or Foreign Country) **Funeral** Min 1MM 2□ F Months Deys Hours 76 Yrs. 213-20-0028 Director Aug.23, 1922 Virginia Usuel Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23s or 28s-f shor traumatic event, the Modical Expirator must be notified at 1 ☐ Yes 2X No Director Howard MD Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9311 All Saints Road 20723 U.S.A. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐No
If Yes, Give
Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or her any injury or other traumatic event. 1 □ Never Merried 2 □ Married Black Baltimore, Maryland 21215-0020 1 Tyes 2 XNo Specify: Specify: p 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montg. Co. Elementary/Secondery (0-12) 5 th College (1-4or 5+) Plant Equipment Operator Board of Ed. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Alice Lewis Samuel Hall 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Allen S. Hall (Son) 9311 All Saints Rd., Laurel, MD 20723 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removei from Stete Meadowridge Mem. Park12/30/98 Elkridge, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850 21. Sig ture of Funeral Service Lice ea and. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heat failure. List only one cause on each line. Approximate interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting In deeth) Cardiomyopathi Examine Due to (or es e consequence ot) Examiner Hypertension physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence ot) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): usa as I signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Myocardial Ag 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en autopsy parformed? has paga 2 1 Yes 2 No 1 ☐ Yes 2M No certificate Hospital or Attending Physician: director, 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) and manner as stated.

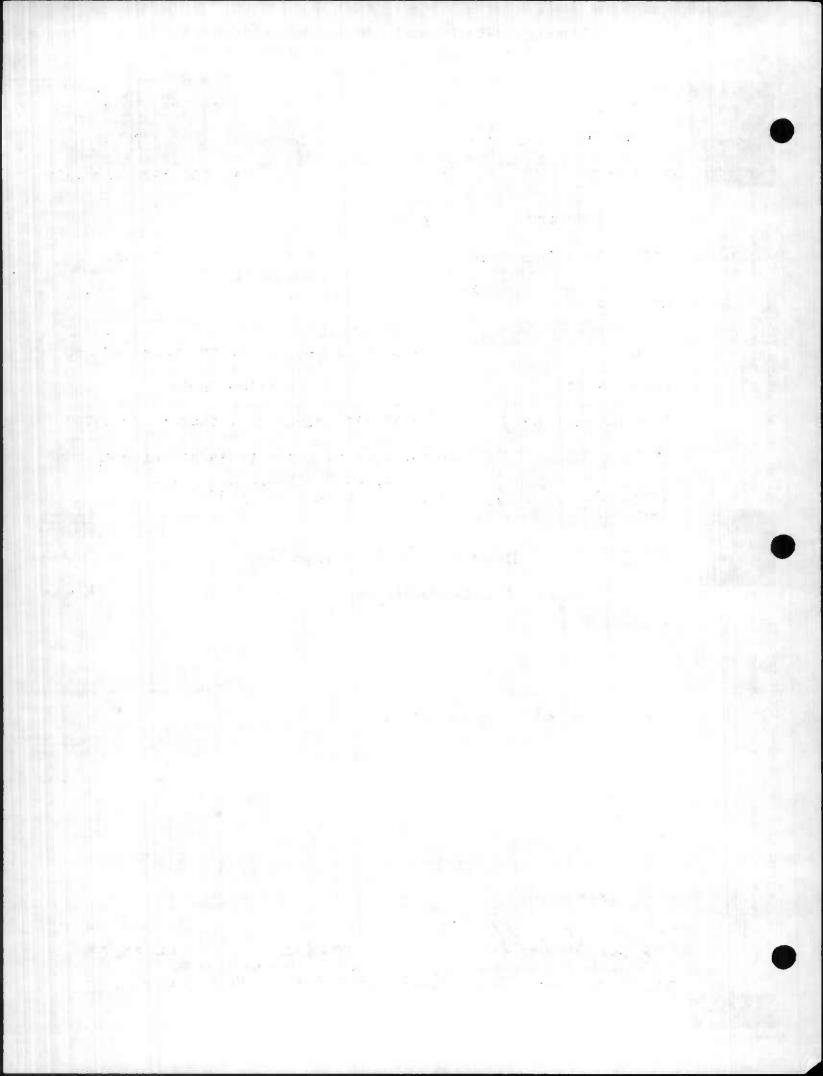
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner stated. edicai 29a. Certifier (Check only one) To the I vithin 2 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signeture and title of certifier 98 D36820 IU Simbell M.D. 30. Name and address of parson who completed cause of deeth (Item 23e) (Typa, Print) 370 Burtonsville MD 20866 National Drive Suite 3905

State Registrar

31. Dete filed (Month, Dey, Year)
DEC 3 0

32. Registrer's Signature

oaks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev

3. Time of Deeth

98

4c. County of Deeth

Dec

Maiden choice lane, Cutonsville, MD, 21228

4b. City, Town, or Location of Deeth

12:25 pm

Physician
/Medicai
Examiner

Elizabeth Marie Hamill

4e. Fecility Neme (If not Institution, give street end number)

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show eny injury or other treumstic event, its Medical Examinal must be notified as

Baltimore, Maryland 21215-0020 **Physicia** /Medica Examine

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the build-transit

Charle	stown	Car.	e Cen	ter			Cate	onsu;	lle	Bo	alto	more
5. Sociel Security Number 403-10-3855		Sex I□M 2⊠F	7. Age ( <i>l</i> n <i>yrs</i> . 88	lest birthday Yrs.	Months	Deys	if Under a	Adin	Date of Birth (Month, Day, Ye, Y		9. Birth	nplece (State or Fore untry) tucky
Usuel Residence of Dec	cedent											
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3 ☑ Widowed 4 □	Divorced	If Yes, Giv Year or De			1 Yes	2 No	Specify:			Specil	y: Wh	ite
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12				Home	maker				01	wn Ho	me	
17. Fether's Neme (Firs	t, Middle, Last)						18. Mothe	r's Name (Fi	rst, Middle, Meid	len Sumer	ne)	
John Muster	man						Ade	eline	Wagner			
19a. Informant's Name/		Type Print)		19h Mai	lino Addros	e (Stract			oute Number, Cit	y or Tour	State 7	in Codel
										-		
Jeanne M. A		(daugh					rry Di	rive,	Gaither		-	
20a. Method of Disposit				Plece of Disp semetery, cri	position (Ne	me of other plea	ce)	C	ete 20c.	Location	- City or T	own, Stete
1 ☑ Burial 2 ☐ Cr 4 ☐ Donation 5 ☐			State					y 12/	31/98 Si	lver	Spri	ing, MD
21. Signeture of Funera			Gat	.e 01	neave	II CE	metery	France	cis J. C	0111	oc Fi	maral
21. Signeture of Furiera	1 Service Licer	7/		r	ZZ. Neme e	Tnc	500	Unive	ersity B	lvd.	West	
RAC	n A	Shive	()	S	Silver	Spr	ing,	MD 20	901	1,44.	west	•
Immediate Cause (Fina disease or condition resulting in deeth)		a. Ena	1 Sta	ge Sas e conse	CO N	gest	ve 1	Hear	t fa	ilur	•	year year
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Conventially list condition		b	Due to (o	r es e conse	auence of	67						/ear
Sequentially list condition if eny, leading to immediate	liete		200 10 (0	1 03 0 001130	squalice of	•					- 1	
Cause (Disease or Injur		c									1	
that initiated events resulting in death) Last			Due to (or	r as a conse	quence of)							
		d										
Port If Other significant	oppditions o		ath hut ant sac	data a la aba			In D - 4 I		OOD DISTANCE			
Pert If. Other significant	Conditions C	outubuting to de	ath but not resi	uiting in the	underlying	cause giv	en in Peri i.			_/		to the cause of de
									1 Yes	2 No	3 🗌 Pro	obably 4 Unkr
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										1		f déath?
									1 Tes	2 2 No	1	Yes 20 No
25. Wes case referred to exeminer?	medical						28. Plece	of Deeth (C	heck only one)		-	
1 Yes 2 No		Hospitel: 1 1 Ir	patient 2	ER/Outpatie	ent 3 D	OA Oth	er: 4 Nu	rsing Home	5 Residence	8 🗆 🔿 🖰	er (Snec	i(h/)
27. Megner of Deeth			f Injury h, Day Year)	28b. Time	-	28c. fnjun Worl			Describe how in			77
	Pending		n, Day Year)	Injury	М							
2 Accident 3 Sulcide 6	investigation Could not be						Yes 2 N					
4 ☐ Homicide	determined	Zoe. Place	of Injury - At ho	ome, ferm, s	treet, fector	y, office		28f.	Location (Street City or Town, St	end Numi	ber or Rui	ral Route Number,
	,	Sandill	a, o.c. (opecii)	,					y o	0/		
29e. Certifier	Certifying Phy	vefcian: To the i	pest of my know	wiedoe dee	th occurred	et the tim	ne dete end	nlere and	due to the cause	(s) and m	enner ec	etoted
(Check only 2	Medical Exam	Mner: On the ba	sis of examinet	tion and/or It	nvestigetion	i, in my o	pinion, deetl	h occurred a	t the time, dete	end piece,	and due	to the cause(s)
Unitely .		end menn	er steted.									
29b. Signeture and titte	or certifier				29	c. Licensi	a number		29d. [	Jete signe	d (Month	Day Year)

ause of deeth (Item 23e) (Type, Print)

State Registrar

10

Samuel March bely have a chapter by he had, Bridge comment of the safety was See the second of the formal second of the s

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician	
/Medical	_
Examiner	

**Funeral** Director

the Meryland ns 23a or 28a-f ahow must be notified at death with Name ; 8 "netural", Hyglene.

filed within 72 hours after Baltimore, Maryland 21215-0020 . Pages 1 and 2 should be fill ment of Heelth end Mental Hant: If item 27 is marked oth jury or other traumatic avan Be permit. Page Department of Important: If any Injury or Physician /Medical Examiner Examiner The law requires that the death certificate be executed pue Box 68760. physician Physician/Medical the for use signed by the a Division of Vital Records, P.O. Be Completed by page 2 should has certificate or Attending Physician: funeral director, Certification: To this After death. within 24 hours after deat To the Funeral Director: filled in Hospital edical completely \$ 10 20

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec 22,1998 Wesley G. Harding 09:13am 4b. City, Town, or Location of Death la Facility Nama (If not institution, giva street and number) 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6 Sax 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Months Days 1☑ M 2□ F 577-16-6331 78 October 31, 1920 Washington, Usuel Residence of Decedant 10c, City, Town or Location 10a. State 10b. County tOd. Inside City Limits Maryland Montgomery Rockville 1⊠ Yas 2 No Director 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 623 Smallwood Road 20850 United States Funeral 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No HYas, Giva World Yeer or Detes: War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yas 2 ☒ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade completed) Veterans Elementary/Secondary (0-12) Collega (1-4or 5+) Administration Judge 18. Mother's Nama (First, Middle, Maiden Sumama) t7. Fathar's Nama (First, Middle, Last) Joseph H. Harding Eva E. Wright 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rita E. Harding/ Wife 623 Smallwood Road, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) December, 29, 1998 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery, Cheltenham 22 Nems and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Deenses M00689 a, or complications that causa the death. Do not anter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Inlarval Between Onset and Death Immediata Causa (Final Asystole 20 min disaasa or condition resulting in deeth) Due to (or es a consequence of): Coronary Artery Disease Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Anoxic Encephalopathy Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 3 NO 1 Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 2/ ER/Outpatient 3 DOA 26a. Data of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28d. Describe how injury occurred 28c. tnjury at Work? Natural 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homleida the Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29b. Signetura aportive of certifier 29c. License number 29d. Data signed (Month, Day, Year) amellen Dec 22,1998

State Registrar

DHMH 16 Rev 6/95

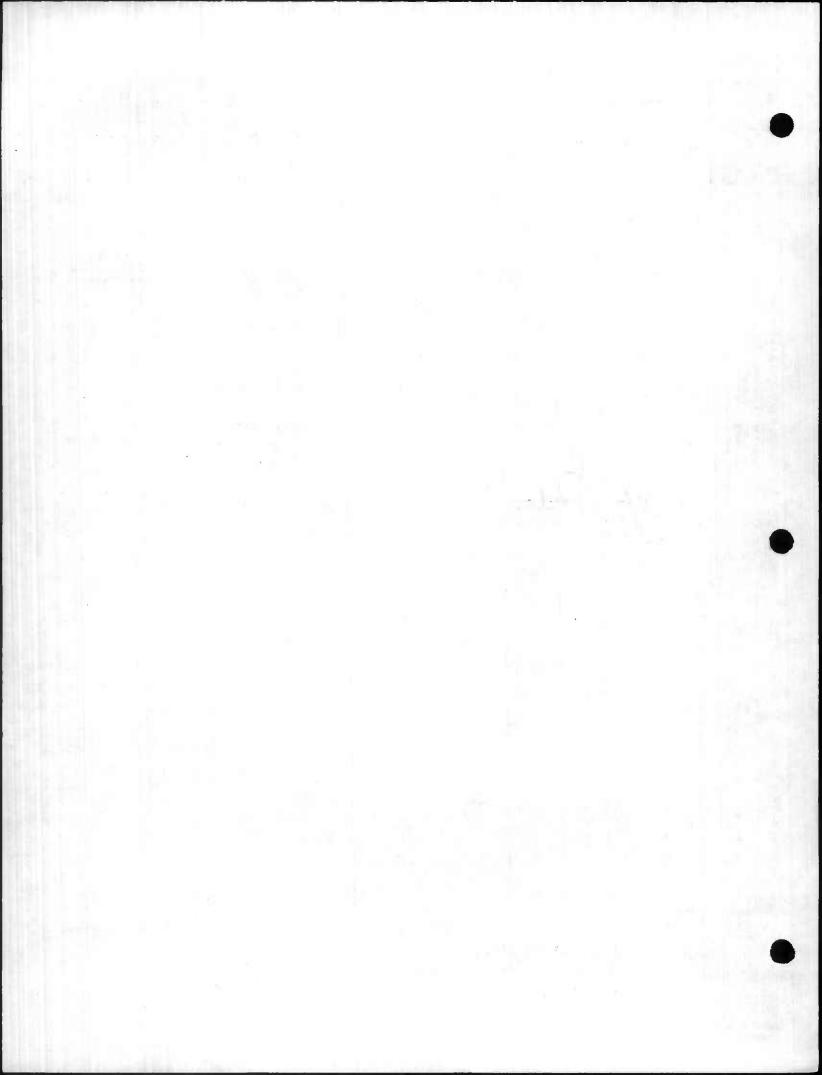
Ave Silver Spring Md 20902

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

Kewal Sharma Md 31. Data tiled (Month, Day, Year)
DEC 28

10620 Georgia

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Jose Balsera Hernandez December 27,1998 20:22pm /Medical 4e. Fecility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville Montgomery 6. Sex 1 △ M 2 □ F Hours Min. B. Dete of Birth (Month, Dey, Year)

Dec. 8,1919 If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys N/A 79 Director Spain Usual Residence of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits from 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Modical Examiner must be notified at Md. Montgomery Montgomery Village 1 ☐ Yes 2 ☼ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 18319 Lost Knife Circle #104 20886 Spain pemit. Peges 1 end 2 should be filed within 72 hours after deeth a Department of Heelth and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever In U,S. Armed Forcas? 14. Race - Amarican Indian, Black, White, atc. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No if Yes, Giva Year or Detes: Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Automotive Car Dealer 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Angel Balsera Josefa Hernandez 0 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18319 Lost Knife Circle #104 Montgomery Pilar Diaz Bese (Wife) Md.20886 Dete 30 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dec. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1998 Metropolitan Crematory Alexandria. Va. 22. Name and Address of Facility DeVol Funeral Home 21. Signeture of Funerel Service Licanse 10 East Deer Park Dr. Gaithersburg, Md.20877 eilles 23a. Part1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Betw Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting In death) /Medical Examiner Due to (or es a consequence of): Examiner physicien and s the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Under vin Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) ettending p 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t d be detech 1 Yes 2 No 3 Probably Unknown by 24e. Wes an eutopsy performed? 24b. Were autopsy findings avellable prior to Completed peen complation of causa of death? page 2 hes 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Inpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manper of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature end title of cartifiar 29c. Licanse number 29d. Dete signed (Month, Dey, Year) December 27, 1978

State Registrar

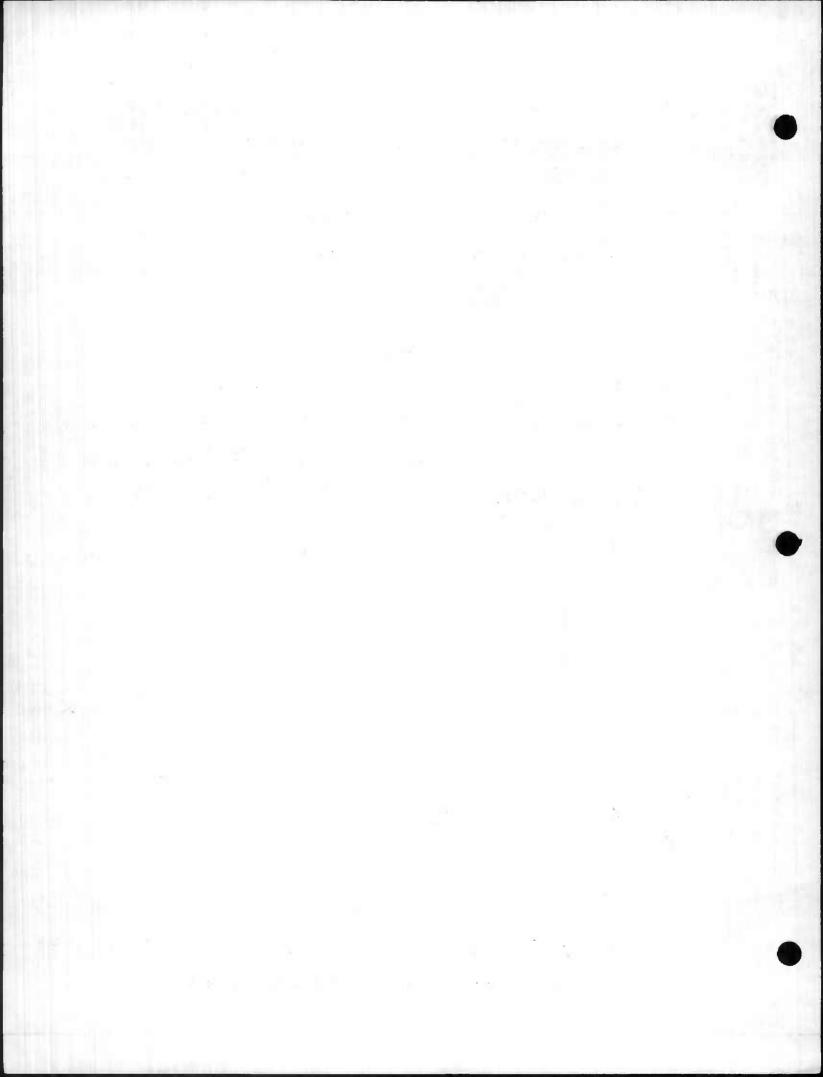
31. Dete filed (Month, Day, Year)
DEC 3 1

Brett Gamma M.D.

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signetura renewa

9901 Medical Center Dr. Rockville, Md. 20850



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Madaway 830 pm Nattor Harrison 29 4a. Facility Nama (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Chestertown Chestertown Nursing & Rehab. Kent Sex 1X M 2□ F If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, July 8, 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) 74 Yrs 218-16-6929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 150 Flatland Road Apt. 56 21620 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 Yas 2 No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black. Whita, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Daily DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Farmer Agriculture 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Sumame) Walter Harrison Hadaway, Jr. Nannie Newcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Helen Bryden/Neice 104 Primrose Road, Chestertown, MD 21620 20a. Method of Disposition 14 Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/4/99 Wesley Chapel Cemetery Rock Hall, MD 21. Signature of Funeral Sarvice Licenses 22. Name and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. Welfenbeln 130 Speer Road, Chestertown, MD lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Intarval Between Onset and Death Immediata Cause (Final disaase or condition resulting in daath) Renal ~ / week Due to (or as a consequenca of): Sequentially list conditions, Dua to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 | Yee 2 | No 3 Probably 4 D'Unknown Homodialypis @345 pt. Stopped dialipis ~ lwk Hgo. ASCUDS; S/PCABG: HTN: DM TypeII: Nophvolithionis 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? Barrets Esophasua: Renal Art. Stonosis 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cese raferred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Director

Funeral

þ

Completed

Be

12

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Important: if lam 27 is marked other than "natural", or hame any injury or other traumatic.

pue physician ate has been signed by page 2 should be detac certificate has the Hospital or Attanding Physician: ' hin 24 hours after death. the Funeral Director: After this certifica

The lew requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be To Certification: filled in by the

1 Yes 2 No

27. Manner of Death

1 Naturel

2 Accidant

4 Homicide

3 ☐ Suicida

29a. Certifier

Other: 45 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number D 50996 29d. Date signed (Month, Day, Year) 12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Neil Stoddard 100 Brown Street, Chestertown, MD 21620 31. Date filed (Month, Day, Year)

26b. Time of

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

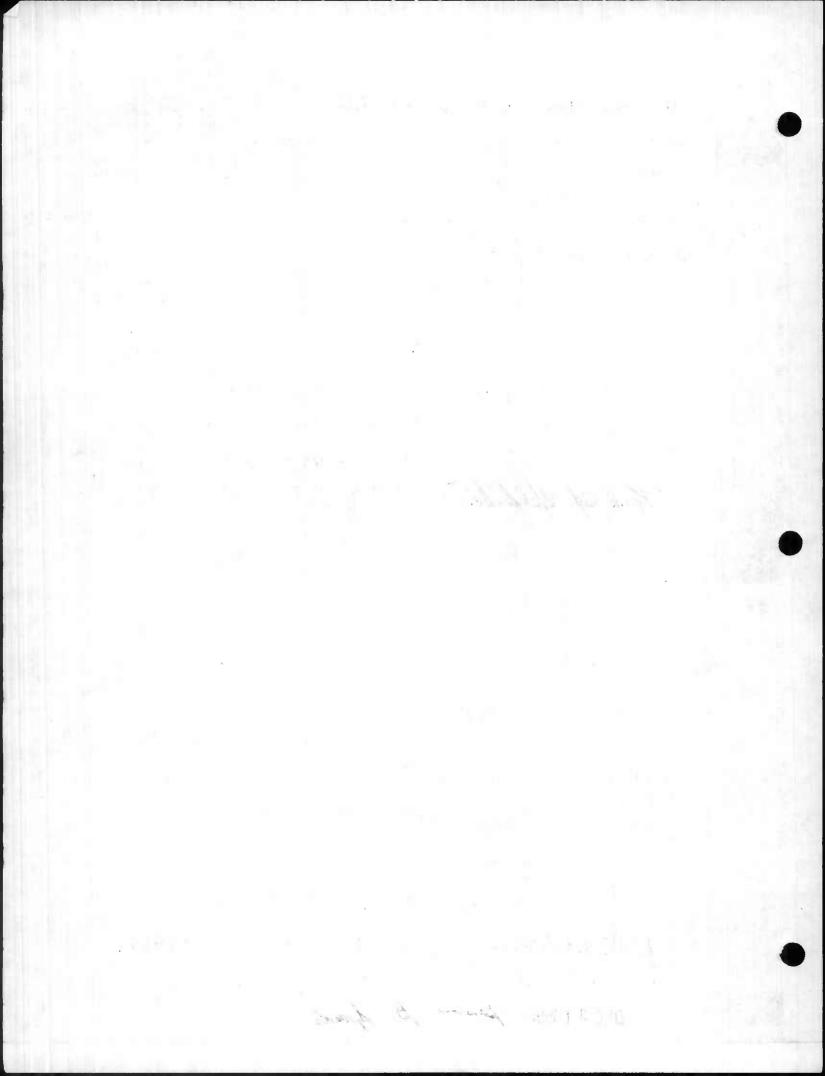
Medical

DEC 3 1



28a. Dete of Injury (Month, Day Year)

within 24 hours a To the Funerei D



**Physician** 

/Medical

1 Decedent's Name (First Middle ( ast)

5. Social Security Number

220-28-4838 Usuel Residence of Decedent

10e. Street end Number

10a. Stete

MARYLAND 10e. Street end

LEON DEAN HUFF

1**X** M 2□ F

4e Facility Neme (If not institution, give street and number)

The Memorial Hospital

10b. County

TALBOT

with the Maryland ir than "naturel", or itema 23a or 28a-f show the Modicel Examiner must be notified at death . 72 hours after is 1 and 2 should be filed within 5 of Health and Mental Hyglena. Item 27 is marked other than "n Baltimore.

attending physician and for use as the burial-transit The law requires that the death certificata be executed Division of Vital Records, P.O. Box 68760, by the a 6 been sig page 2 s certificate Physicien: this After this or Attending s after death.

I Director: After od in by the fur

117 CHOPTANK AVENUE 21601 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Status NO Yea 2 No If Yes, Give Yeer or Detes:1951-54 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 REPAIRMAN TELEPHONE 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Heath and Menta Important: if item 27 is marked eny injury or other traumatic events. IVAN HUFF GERTRUDE GEISE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MOIRA F. HUFF /WIFE 117 CHOPTANK AVE. EASTON, MARYLAND 21601 20b. Pleca of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 12-24-98 CHESAPEAKE CREM. CTR. CHESTER, MD. 22. Name end Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME CFSP 200 S. HARRISON ST., EASTON, MD. 21601 23e. Pert . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical lung carcinoma **Examiner** Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequença of) Physician/Medicai Due to (or as e consequence of) 23b. Did tobacco use contributs to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 1 worse by 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 3 No 1 ☐ Yea 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as steted. 29e. Certifier edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier D10938 Robert W. Trever, M.D. 12-24-98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7696 OCEAN GATEWAY ROBERT W. TREVER, M.D. EASTON, MARYLAND 21601 31. Date filed (Month, Day, Year) 32. Registrer's Signature DEC 2 8 1998 Registrar **DHMH 16 Rsv 6/95** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

10f. Zip Code

Deys

Months

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

EASTON

66

2. Date of Death

Dec

If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year) NOV . 16,1932

4b. City, Town, or Location of Death

Easton

23

1998

PENNA.

4c. County of Deeth

10g. Citizen of What Country?

Talbot

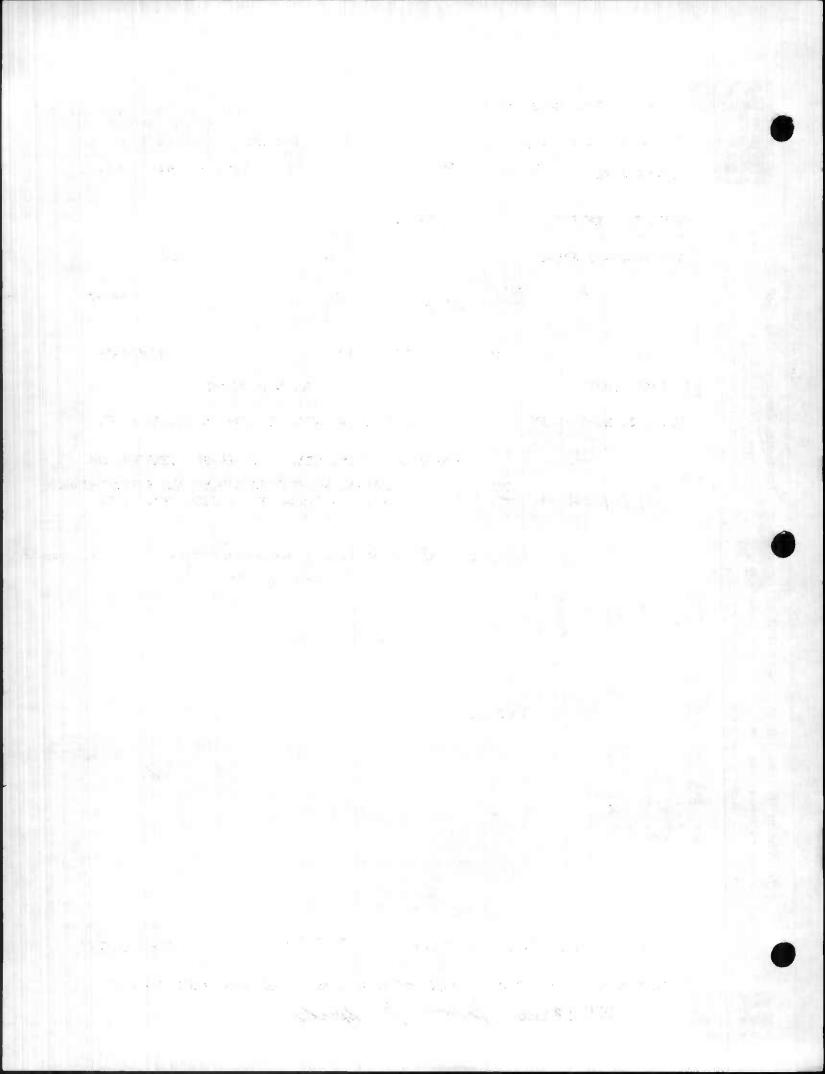
3. Time of Death

5:15PM

9. Birthplaca (State or Foreign

10d. Inside City Limits

Yes 2 No

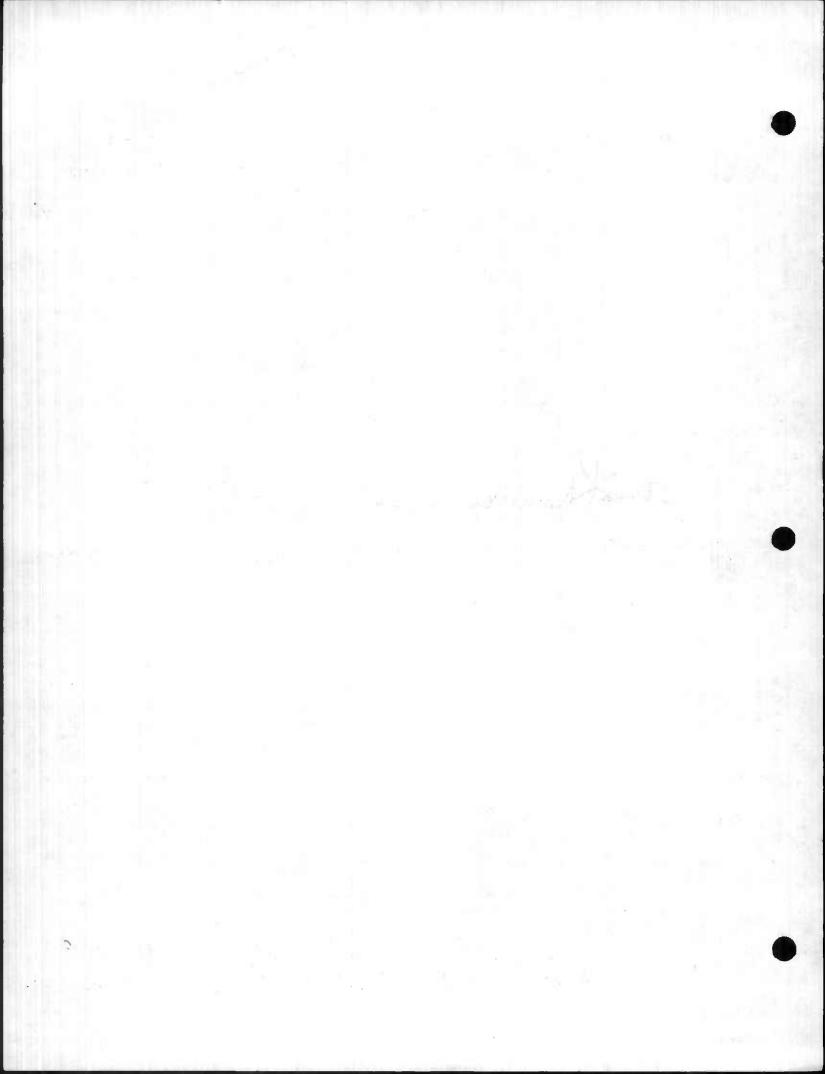


# Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate o	f Death	,	Reg. No.	1	3 1 1
		1. Decedent's Neme (First, Middle, I	Last)					2. Dete of De	eth		3. Time of Death
	Physician /Medical	SAMUEL		INTRA	TER			Month DECEMBE	R 30 1	Year 998	2:00AM
	Examine	4e Facility Neme (If not institution, g	rive street and number				4b. City, Town, or !				
		SUBURBAN HOSPIT	AL				BETHESDA		MONTG	OMERY	Z
	Funeral	Social Security Number 6.		ge (In yrs. la		If Under 1 Yes		8. Dete of Bir (Month, Da	th	9. Birthr	place (State or Foreign
	Director	033 22 1432	1XDM 2□ F	73	Yrs.			MARCH 2			INOIS
	pu *	Usuel Residence of Decedent  10a. State 10b. County		10c City	Town or Loca	ntion					10d, Inside City Limits
	ahow		ERY	BETHE		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 ☐ Yes 🏋 No
	with the Mar a or 28a-f at be notified	10e. Street and Number		10000		10f. Zip Code			10g. Citizen of	Mhat Cou	
	the with	C701 MET ODY TANE									my r
	ther death with the Maryland r terns 23s or 28s-f show niner must be notified at	6701 MELODY LANE	12. Wes Decedent	Ever in II S	13 W	20817	/ Hispanic Origin? /S	necify Yes or No		SA ce - Americ	can Indien,
MILE.	1 28 3	1 Never Merried 2/7/Married	Armed Forces	?	H.	res, specify Co	f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)	Ble	ck, Whita,	
2	urs af	3 ☐ Widowed 4 ☐ Divorced	11 Yes 2 ☐ If Yes, Give Yeer or Detes:	110	10	☐Yes 2X N	lo Specify:		Specif	Y:WHII	CE
45 Am	within 72 hours after one. than "natural", or its he Wedes Emining				16a. Decede	nt's Usuel Occ	cupation		16b. Kind of B	usinass/In	dustry
2	led within 72 ho lygiene. Nor than "naturn It, the Medical	(Specify only highest of Elementery/Secondary (0-12)	rade completed)  College (1-4or	54)	(Give ki	nd of work dor NOT use reti	ne during most of wor ired)	king			
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7	be filed in the dother avent, the Co	17. Father's Neme (First, Middle, La	st)				18. Mother's Nan	ne (First, Middle,	Maiden Sumer	ne)	
5	should be and marked o marked o marked o To Ro	CHARLES INTRATER					CELIA HO	DLLANDER			
80	2 2 2 2	19a. Informant's Name/Relationship					et and Number or Ru				
_	CENA	NATALIE INTRATER	/WIFE				LANE BETHE			2.081	
A-30-	8620	20a. Method of Disposition 1,□ Burial 2 □ Cremation /3	Removal from State		netery, crema	tion (Name of itory or other p	olace)	Date	20c. Location	- City or To	wn, Stete
1	Pagment:	4 □ Donation 5 □ Othe (Spec	cify)		AN MEM	ORTAL	GARDENS !	1/3/99	OLNEY M	ARYLA	ND
6	permit. Page Department of Important: If any Injury or phos.	21. Signature of Funeral Service Lic	ensée		22. I	Neme end Add	tress of Facility Y GOLDBERG	MEMORT	AT CHAP	FISI	NC
(h)	20529	Court 1	VenVCr		11	70 ROC	KVILLE PIK	E ROCKV	ILLE, MA		
V		3a. Part1. Enler the disease, or co shock, or hear feilure. List on	mplications that cause	d the deeth.	Do not enter	the mode of d	lying, such as cardiac	or respiretory a	rrest,	1	Approximate Interval Between
	Physician			,	h 1					1	Onset and Deeth
	/Medical Examiner	disease or condition	Cex	ebro	l h	emo	rrhage	0			3 durs
		resulting In death)		Due to (or	as a conseque					1	7
	icets be assected I physician and Is the burish-transit		b							- 1	
	ifficate be associted by physician and as the burishransit	Sequentially list conditions, if any, leading to immediate		Due to (or a	as a conseque	ence of):					
9	ician burla	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C							i	
09260	phys cate	resulting in death) Last		Due to (or a	is e conseque	ence of):					
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, 0	death cert e attendin ed for usa										
20	that the death ce ed by the attendit detached for use	Pert II. Other significant conditions	contributing to death I	but not result	ing In the und	lerlying cause	given in Pert I.				o the cause of death?
500	es that the igned by be detacted by Phy							10	Yes 211No	3∐ Pro	bebly 4 Unknown
Intracto	The lew requires that the death certificate has been signed by the attending page 2 should be detached for use a Completed by Physician/M							24a. Was	an autopsy	24b. W	ere autopsy findings
5	v requir been s should								ermed?	CO	vailable prior to ompletion of cause death?
7	The lew ste has bege 2 s								7 -56		
	dicten: The lever certificate has rector, page 2	OF Was seen referred to madical	1					10		11	☐ Yes 2☐ No
2 5	Physician: this cartific ral director,	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	all 5	010 10 10 11	a□ pos (	26. Place of Dea			(0)	4.3
Samuel	Ing Physicien: The interpretations of the page fundamental director, page iden: To Be Comited the comited that the page iden: To Be Comited the page iden: To Be Comited that the page iden: To Be Comited that the page iden:	27. Menner of Death	28a. Dete of inju	ury 2	P/Outpatient 8b. Time of	28c. In	4 LI NUISING H	lome 5 Resi	how injury occu		<i>y</i> )
7 8		1 Accident 5 Pending investiget	(Month, Di	ay Year)	Injury		Vork? ☐ Yes 2 ☐ No	-			
5	after death Director: / d in by the	3 Suicide 6 Could not	be 28e. Pleca of In	jury - At hom	ne, ferm, stree	ot, fectory, offic	<b>&gt;</b> 0	28f. Location (	Street and Num	ber or Run	at Route Number,
É	din din	4 Homicide	building, e	(c. (Specify)				City pr-To	wn, State)		
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After a completaly filled in by the funeral Medical Certification:		hysician: To the best								
	n 24 n 24 ne Fu	(Check only 2 Medical Expone)	end menner st	of examinetic teted.	n and/or inve	stigation, in m	y opinion, deeth occu	rred et the time,	date end plece,	and due t	o the cause(s)
	Within To the Comp	29b. Signature end title of certifier	- 0-			29c. Lice	ense number		29d. Date signe	d (Month,	Day, Year)
	7.	/w. / Tul /	OF M	10		11	2/421	- /	1/2com	10-2	h ACK
	10	30. Nama and addrass of person wh	o completed cause of	death (Item 2	23a) (Type, Pa	rint)	~ / / / /	1 1 0	,	7	1110 Pring 20102
		Ira Paul KVE	Ettina 1	NO	715	11 MG	dical K	6-1( Dr.	ve SII	yor5	rese 7 DAM
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	Registrar	DFC 2 T	1998		1.	Mon					

DHMH 16 Rev 6/95

Samuel Intrater



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Dec 26,1998 Clara Jackson 09:50pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 6. Data of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 DF 102 21, 1896 Director Nov. 577-26-2196 Maryland **Usual Residence of Dece** the Meryland 10a. State 10b. County 10c. City. Town or Location se filed within 72 hours effer deeth with the Marylan of Hyglens. The funder than "sthrel", or farms 23s or 28s-f show went, the sense framos man be notified it went, the sense framos man be notified in 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 Grosvenor Lane 20814 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department Stores / Elementary/Secondary (0-12) College (1-4or 5+) Blair House 8 Elevator Operator / Cook 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filt ment of Heelth and Mentel Hant: If them 27 is marked oth jury or other traumatic even Be (Unavailable) Reddix Unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 20017 ate 20c. Location - City or Town, State Cheryl Fish-Parcham (friend) 1347 Newton Street, NE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 12-29-98 Washington, DC 22. Name and Address of Facility
Rapp Funeral Services, P. A. 21. Signature of Euneral Service Licensee Seen 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final Dehydration disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Altered mental status physician end the buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): acute urinary tract infection Box 68760. Physician/Medical Due to (or as a consequence of): Diabetes mellitus . 980 been signed by the atter should be detached for i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ă Unknown Senile Dementia Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? ASCVD completion of cause of death? has page 2 1 Ves 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AO ( 15 3 Dec 28,1998 017719 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

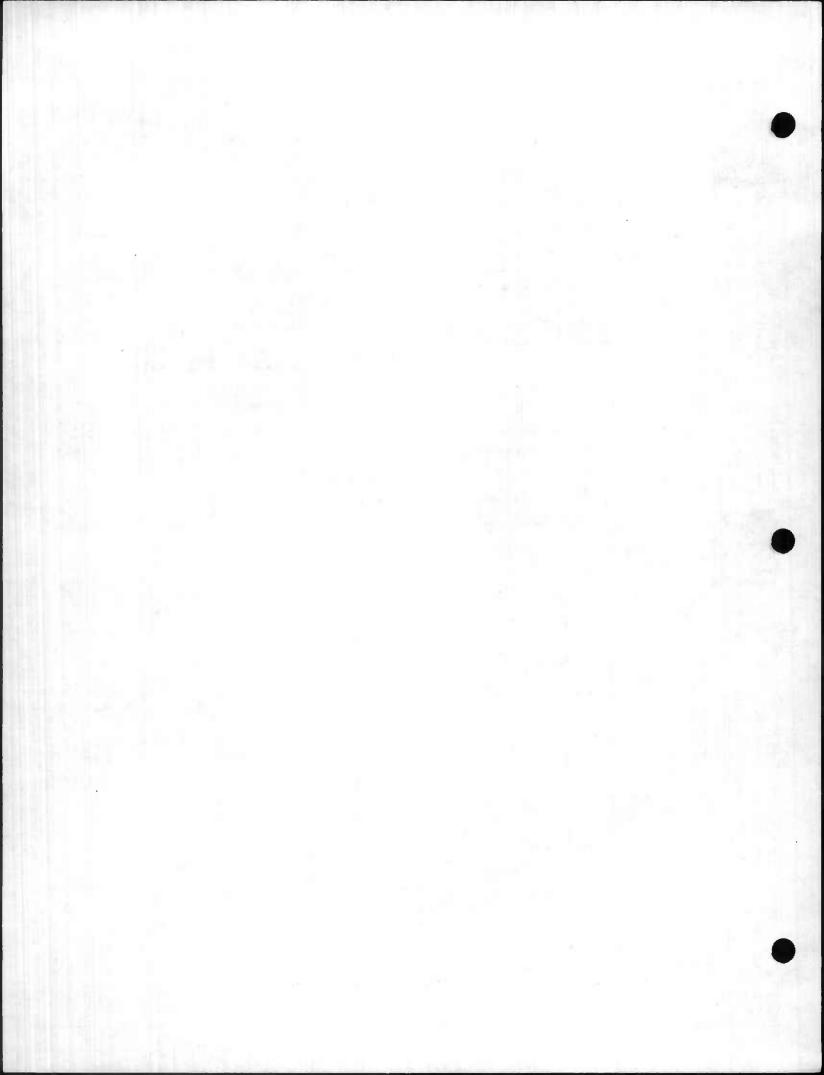
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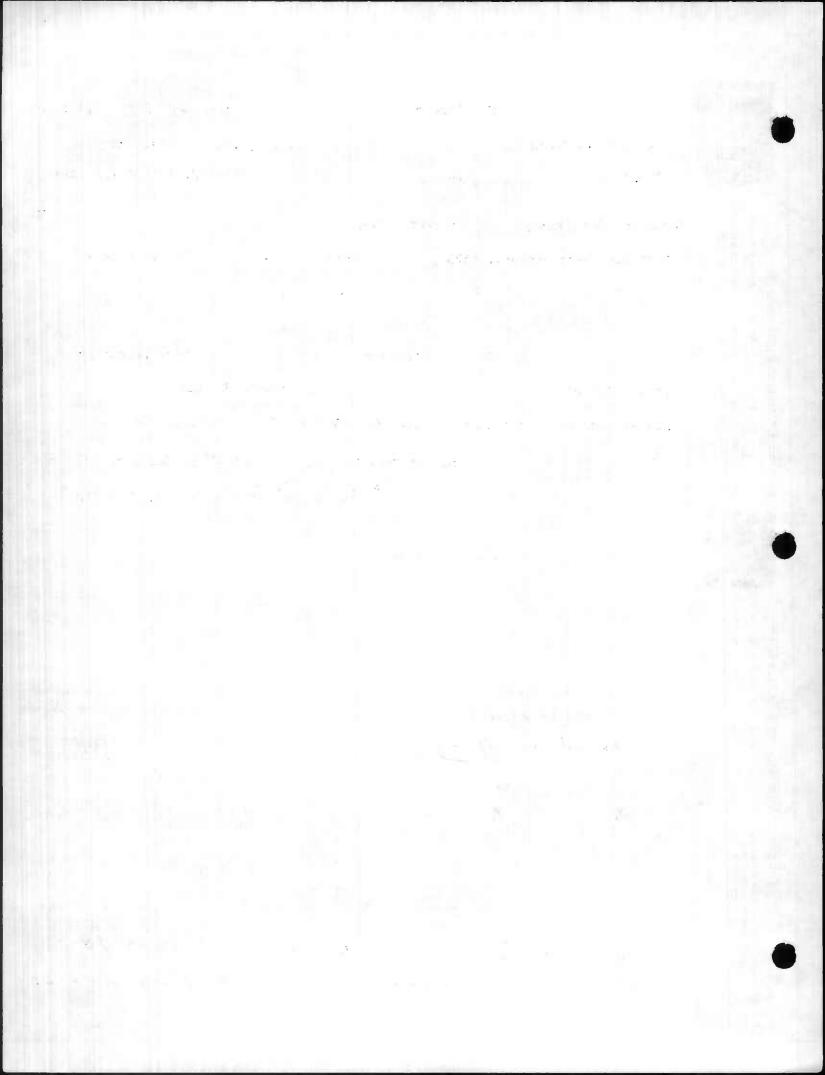
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George Patrick III MD 9221 Colesville Rd Silver Spring Md 20910

32. Registrar's Signature



		State of I	viaryian		anmen rtificat			ına IV	iental H	ygier Reg. i		4)	IU	2
1. Decedant's Nama (First	, Middla, Last	)							2. Data of D		Dav	Yaar		a of Death
n al		Leo M.	Jaco	bs					Dec	24	1 19	98	10:	50 Pm
4a Facility Name (If not in	stitution, give	street and numb	er)						cation of De		4c. County			
Holy Cros	SS Hosp		Age (in yrs.	food blieth els vi	If Under		Silve   If Undar		ring	[ ]	Montg	omery	1000 (640	to as Familia
570-07-608	5 15	M 2□ F	80	Yrs.	Months	Days	Hours	Min.	8. Data of E (Month, I July 1	Day, Yea	1918	Calif	forn:	ta or Foraign La
Usual Rasidance of Deced	County		10c. City	y, Town or Le	ocation							10	Od, insid	a City Limits
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Maryland   Mo	ntgome	ГУ	211	ver b	10f. Zip	Coda				10g. (	Citizen of V	Whaf Coun	fry?	
1400 East	Jest H	i ohwav.	#423		20	910				Un	ited	State	es	
11. Marital Status		12. Was Deceda	nt Evar in U,	S. 13.			ispanic Original	gin? (Spe	ecify Yes or N Rican, atc.)	10-		e - Amaric		1,
1 Never Married 2  3 \$\forall \text{Widowed} 4 \square Di		1 Yas 2	<b>∑</b> No		1 Yas		Specify:	, ruaito	Filoan, atc./		Specify			
15. De	ecedent's Edu	cation		16a. Dece	dant's Usua	al Occup	ation			16b.	Kind of B	usinass/Inc		
(Specify only	highast grad	a completed) Collega (1-4)	or 5+)	(Give	bo NOT us	rk dona i sa ratired	during mosi f)	of work	in <i>g</i>					
		5+		Teac	her					De	af Ed	ucati	ion	
15. D. (Specify only) Elementery/Secondary ( 17. Father's Name (First, II	Aiddie, Last)								(First, Midd		en Suman	na)		
Monroe Jac	obs			1					Kees					
19a. Informant's Name/Ra									al Route Num					
Sheila Jac		(daugh		4101	Howe		eet,	#100	Date Date		d, CA	City or To		
1 □ Buriai 2 □ Cren	ation 3 DF		ite C	emetary, cra	matory or o	ther plac								
4 Donation 5 DO		- 1	Sur	set V					-4-99	E1	Cerri	.to, (	Cali	fornia
21. Signature of Funeral S	ervice Licens	. Re	م	R 9	app F 33 Gi	uner st A	al Se	rvice, Si	es, P	A. Spri	ng, M	D 209	910	
Sequentially list condition if any, laading to immadia cause. Entar Undarlying Causa (Disaasa or injury thaf initiated evants rasulting In death) Last  Part II. Other aignificant of Disaster Causa (Disassa or Injury thaf initiated evants as a cause of the cause of	ia {	5		r as a conse										
Part II. Other aignificant c	onditions cor	ntributing to deat	h but not rasi	ulting in the s	ındariving c	ausa div	an in Part i		23b. Di	d tobac	co uee co	ntributa to	the cau	sa of death
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Res	ral	melli	licrei	rey					24a. Wa	as an au ríormed		ava	ailable pi	osy findings flor to of cause
Res									10	J Vos	aXNo	10	Yes	2□ No
25. Was case referred to r	nedical						26. Place	of Deat	h (Check on)	y one)				
examiner? 1 Yes 2 No 27. Mennar of Daath		lospital: 1 Inp 28a. Data of I (Month,		ER/Outpatie 28b. Tima o		OA Oth	4LINU	irsing Ho	ma 5□Re 28d. Dascrib				y)	
2 Accidant	Panding invastigation Could not be				М	10	Yas 2	No	006 1	104	and Mr.	har co D	d Dante	Mumber
4 Homicida	determined	28a. Placa of building,	Injury - At he atc. (Specify	oma, farm, st	raat, factory	y, office			City or 1	own, Si	ana rvumi lata)	ber or Rura	II HOUTE	vum <i>ber</i> ,
27. Mennar of Death    Naturel   5     2   Accidant   3   Suicide   6     4   Homicida    29a. Cartifiar     Check only one	artifying Phy- edical Exami	elclan: To the be nar: On the basis	st of my kno s of axamina stated.	wladga, daat tion and/or Ir	h occurrad nvastigation	at tha tir , In my o	na, data an pinion, dea	d placa, th occurr	and dua to the	a cause a, data	a(s) and mand place,	annar as si and dua to	tated. tha cau	sa(s)
29b. Signature and title of	certifiar				290	c. Licans	e number					d (Month,		er)
D	a. 1	. 50				7/3	54	8		1	2.2	1.9	8	
30. Nama and address of p	person who co	omplated causa o	of death (Itam	23a) (Type					Suite					0 20901
31. Data filad (Month, Day	Veer!		strar's Signa	tura /		rock							-	



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 27, Month **Physician** December 1998 Jamgochian Hrant 2:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring ar Hunder 24 Hrs. 8. Date s Hours Min. Mo Holy Cross Hospital Montgomery 8. Date of Birth Month, Day, Year Jan. 1, 1907 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Months Days 91 Director Turkey 577-82-3564 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d, Inside City Limits "natural", or itema 23a or 28a-f show solical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? #8 20906 Funeral Lebanon 3764 Bel Pre Road. death 12. Waa Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Watchmaker 6 Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 Is marked othe any Injury or other traumatic avent, pages. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hovnan Jamgochian Eghisapeth (Unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Zevart H. Jamgochian (daughter) Same as 10 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-29-98 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral Services, P. A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPTICEMIA WEEK Examine Due to (or as a consequence of): Examiner ician and burial-transit that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician the buria Physician/Medical Due to (or as a consequence of) 88 for usa signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown DIAGRIES MELLITUS; OSTEOMYELITIS OF JAW; Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? RECURLENT PURUMONIA; HYPERTENSIVE CANDIOUASCULAL 1 Yes 2 No 1 ☐ Yes 2 ☐ No DISEASE of Vital Physician: 25. Wea case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Nonpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Division or Attanding 1 Diatural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical completaly (Check only one) within 2 To the 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Meeter c Du D08944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 FARLAGUT AUR. MAKTIN C. SHARGEL M.D. KRAGINGROW - GM 20895 31. Date filed (Month, Day, Year) DEC 28 32. Registrar's Signature State

**DHMH 16 Rav 6/95** 

Registrar

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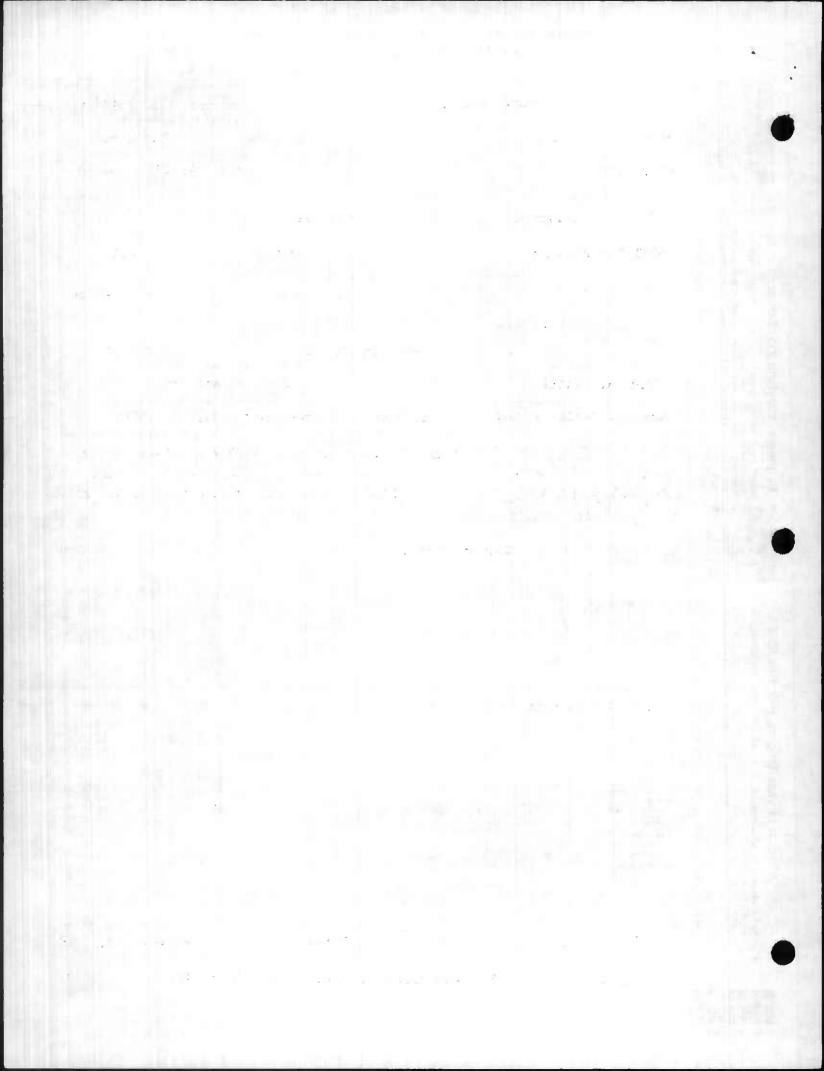
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Arriend #3, #9, 12/30/98, EMW, Mont Stees of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Physician Anthony Kalil, Jr. December 22, 1998 4:10 -P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Bethesda 6923 Barrett Lane Montgomery 8. Date of Birth (Month, Day, Year) Aug. 14, 1935 If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** Days Months 12 M 20 F Hours 63 262-50-8231 Director Usual Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. Cltv. Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothled at 1 No Yes 2 No Directo MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6923 Barrett Lane 20814 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 X Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 Tes 2 No Specify: Specify: White p Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Heelth and Mentel Hygier important: If Itam 27 is marked other th any Injury or other traumatic avent. Ita-Antique Dealer Antiques 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Redmond Ford A. Kalil 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6923 Barrett Lane Bethesda, MD 20814 Renee R. Kalil -20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 12/26/98 Silver Spring, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016 23a. Part 1. Effer in disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure the ist only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** fmmediete Cause (Finei diseese or condition resulting In death) /Medicai 1 Year Cancer of Lung Examiner Due to (or as a consequence of): Examiner certificate be executed physician and the burief-fran Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medicai Due to (or as e consequenca of): 88 USB. 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the detached signed by 1X Yes 2 No 3 Probably 4 Unknown Arteriosclerotic Heart Disease ģ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peen page 2 has 1 Yes 2KING 1 Yes 2 No certificate Division of Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of fnjury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Panding after death. Director: Aft 1 🗌 Yes 2 No 2 Accident Investigation 6 Could not be datermined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida 24 hours a Hospital 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical etely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 15049 December 23, 1998

State Registrar John F. Gustafson, M. D. 5480 Wisconsin Ave.

Dec 28 1998 32. Pegistrar's Signature G. Apocks

#1625 Chevy Chase, MD

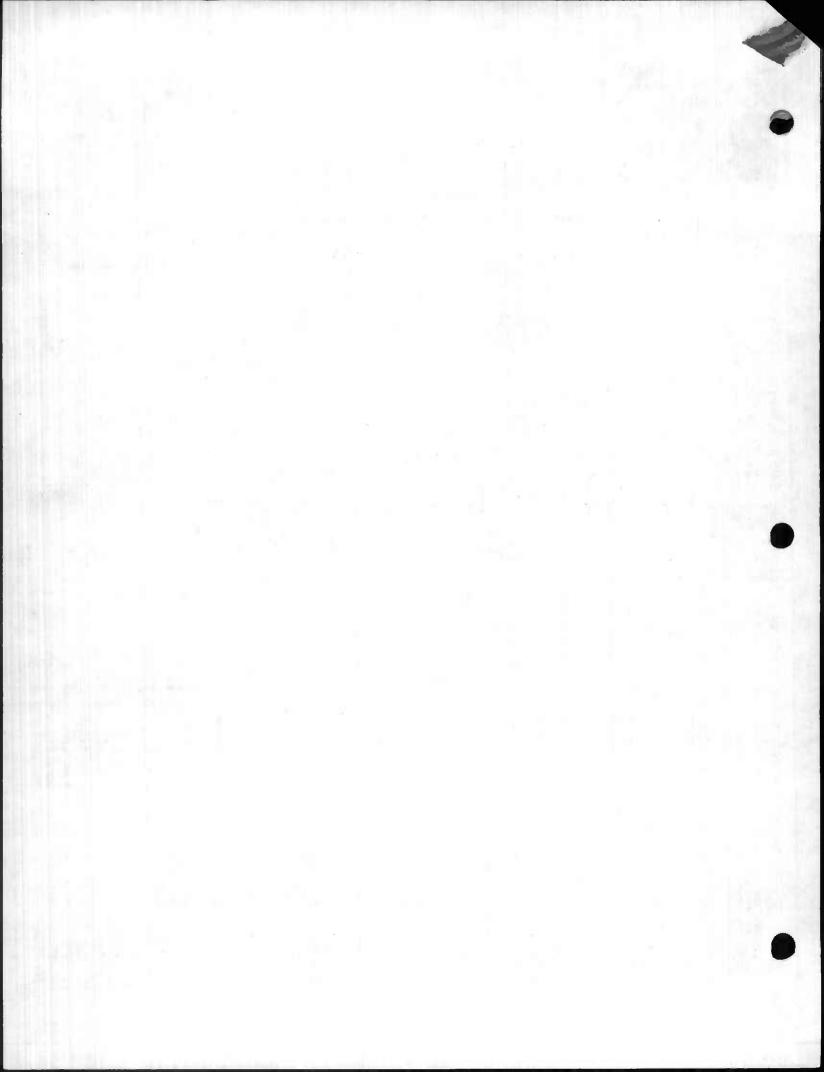
30. Name and andress of person who completed usa of death (Item 23a) (Type, Print)



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1, 1/6/99, BMW, Montg. Co.per physician Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:05 AM CHUL Ation of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Takoma Park WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State of oreign Country) 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 1) M 2 F 40 Yrs. Director MARCH 4, 1958 KOREA NONE Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes XXNo Director MONTGOMERY POTOMAC 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 7612 CODDLE HARBOR LANE 20854 KOREA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: KOREAN by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MEDICAL DOCTOR MEDICINE permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 2 TAEK IL KIM OKBIN IM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WON CHUL KIM / BROTHER 10709 PEBBLE BROOK LANE POTOMAC MD 20854 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremation 3 Removei from Stete 12/30/98 OLNEY MARYLAND 4 Donation 5 Other (Specify) NORBECK MEMORIAL PARK 22. Name and Address of Fecility
HINES-RINALDI FUNERAL HOME, INC. 21. Signeture of Funeral Service Licenses 10 mg 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heer teilure. List only one cause on each line. Approximate Intervei Between Onset and Deeth **Physician** stric Carcinoma Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner attending physician and for use as the buriel-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy peen The lew 1 Ves 2 Divo 1 ☐ Yes 2 ☐ No certificata of Vitai Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 10 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mann Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? edical Certification: 28b. Time of 28d. Describe how injury occurred After Division 1 etural 5 Pending investigation after deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, term, atreet, tectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as attated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifie (Check only one) 29b. Signature and title of contitier 29c. License number 29d. Date aigned (Month, Day, Year) O 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Berustein MID 7610 C arrell 18ve # 250, Takoma Park MD 20912 31. Date filed (Month, Day, Year)
DEC 2 9 32. Registrar's Signeture State Registrar

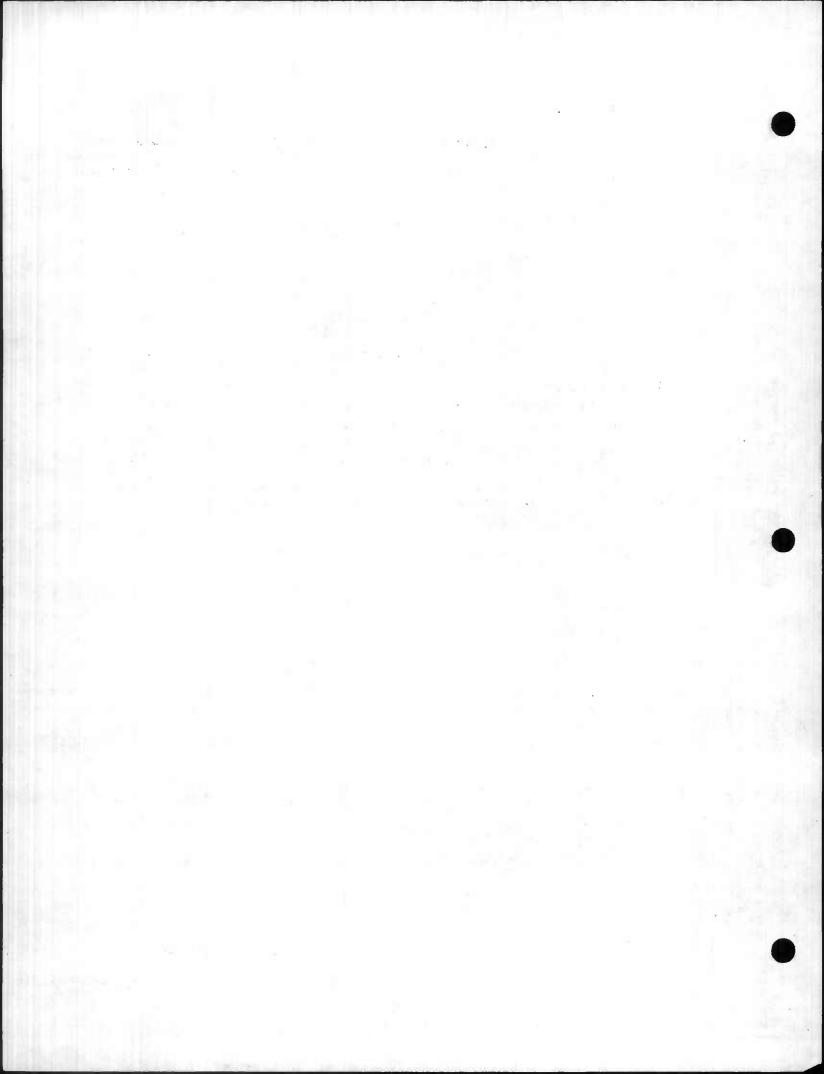
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State of Maryland / Department of Health and Mental Hygiene 8

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	mery Gene							Olney Montgomery						
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10a. State	10b. County		10c. City	, Town or Loc	cation					10d.	. Inside City Limits			
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		5+		Paten	t Att	orn			Law	-				
17. Father's Name	First, Middle, Last)						18. Mother's Ne	me (First, Middle	, Maiden Surnam	ne)				
Milton	H. Kreid	er					Maude	Riggle	S					
19a. Informant's No	me/Relationship (7)	ype, Print)		19b. Mailing	g Address (	Street	and Number or R	ural Route Numb	er, City or Town,	Stete, Zip Co	ode)			
	d B. Krei										20906			
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23a. Part1. Interior disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock in heart failure. List by cause on each line.  Approximate Intervel Bely														
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tmmediate Cause (	6	hours												
tmmediate Cause (Finel disease or condition resulting in death)  Lute cerebral Bleed  Due to (or as a consequence of):  Stv8 ke											hours			
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					and and				Yaa 2 No	3 Probeb	-			
-17/2	ial fi	4	4											
(it	160 4	Gulla:	kari					24a. Was	an autopsy med?		autopsy findings			
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examiner? 1 ☐ Yes 2 ☑	No F	Hospital:	ant 2DI	ER/Outpatient	3 DOA	Oth	or.	Home 5 ☐ Resi		ner (Specify)				
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3 ☐ Suicide	6 ☐ Could not be determined	28e. Place of In	jury - At ho	me, farm, stre	et, factory,	office			Street and Numb	ber or Rural R	Route Number,			
A C Manufald		building, el	c. (Specify	,				City or To	wii, 31818)					
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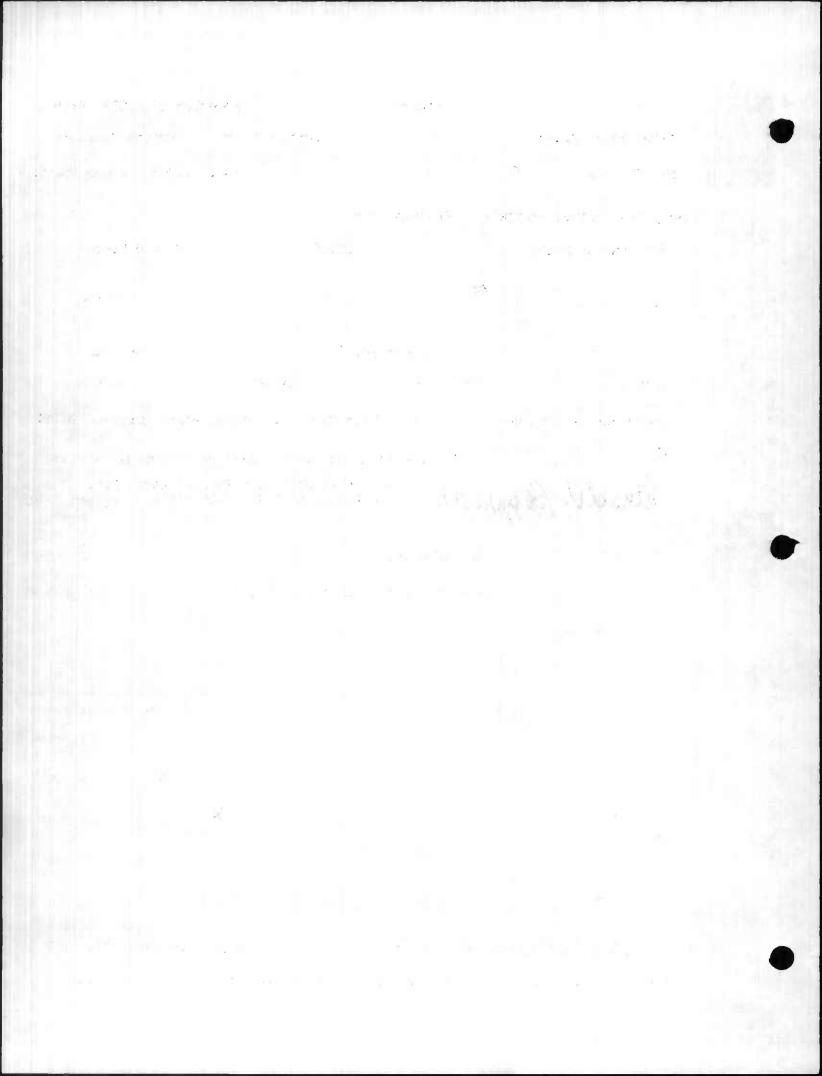
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Funeral Director	5. Social Security Number 6. S 578–76–1228  Usual Rasidance of Decedant	ax □ M XX F	s. lest birthday) If Undar 1 Months I	Year If Undar 24 Hrs Deys Hours Min	O. Date of Date	Year) 1905	9. Birthplaca (Stata or Fora Country) Pennsylvania			
4 show	10a. State 10b. County Maryland Prince (		City, Town or Location Ollege Park				10d. Inside City Lim			
3a or 28a-f s at be notified if Director	10a. Street and Number 5715 Vassar Driv	ve	10f. Zip C	oda 0740	1	Og. Citizen of W United				
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or with the second of the seco	29b. Signature and titlerof certifier  Muchael	Berard,		D 262			(Month, Day, Year) er 28, 1998			
1	30. Nama and addrass of parson who michael Berard, N	complated cause of death (Ita 1.D. 7305 Balt	am 23e) (Type, Print) timore Ave.,	#107 Colle	ge Park,	Marylar	nd 20740			

State Registrar

31. Deta filed (Month, Day, Yaar)
DEC 29 1998

32. Registrar's Signatura

Sparker



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Ves Josephine Powell Kain December 29 1998 1747 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Queen Anne's Hospital Kent & Chestertown Kent If Under 24 Hrs. 8. Dete of Birth Hours Min. November 12, 1911 9. Birthplece (Stett Country) Mary Land 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1□ M 2XF Deys 87 Yrs. Director 218-20-6403 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 Yes 2 No Director Maryland Kent Chestertown 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 200 Morgnec Road 21620 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: if I tem 27 Is marked other than any Injury or other traumetr. Elementery/Secondery (0-12) College (1-4or 5+) Clerk United States Postal Service 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Alex Powell Sara Newnam 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Adelaide Ernest/Sister 700 Crystal Beach Road, Cecilton, MD 21913 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Galena Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/3/99 Galena, MD 21. Signeture of Funerel Service Licansee 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

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Approx Approximate Interval Between Onset and Deeth Physician Small Bowel Obstruction Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentielly list conditions, it eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequenca of): P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? lower lope preumome 1 Yae 2 No 3 Probably 4 Unknown Records. Be Completed by 24b. Were autopsy findings eveileble prior to completion of cause of death? te Atual Fibrillation & Hutter 24a. Wes en eutopsy performed? Serule Dementia (4) 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: '24 hours aftar death. Funeral Director: After this certifica taly filled in by the funeral director, g 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Department 2 ER/Outpetient 3 DOA 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours aff To the Funeral Di completaly filled in 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edical ( 29e, Certifier 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) St., Chestertown, no

Registrar

State

K. WUN

31. Dete filed (Month, Dey, Year)

223

32. Registrar's Signeture

action from the opening

#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 7:15 A.M. 24, 1998 DECEMBER MARGERY BLUMENAUER LANGE 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death MONTGOMERY OLNEY 3605 BLANKENSHIP COURT If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yaer) Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 M XXF 51 Yrs. OCT. 15, 1947 WASHINGTON, D.C 215-48-1610 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND MONTGOMERY OLNEY 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 10a. Street and Number 3605 BLANKENSHIP COURT 20832 OF AMERICA 12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yes XX No if Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yas XX No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOME MAKER 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) JULIA ELIZABETH BISTLINE THOMAS WILLIAM BLUMENAUER, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3605 BLANKENSHIP COURT OLNEY MARYLAND 20832 ROBERT GEORGE LANGE (HUSBAND) 20b. Placa of Disposition (Name of cametery, cremetory or other place) DEC.29, 20c. Location - City or Town, Stata 20a. Method of Disposition 1XX urial 2 Cremation 3 Ramoval from State PARKLAWN MEMORIAL PARK 1998 ROCKVILLE MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 21. Signature of Funeral Service Lice 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-289 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, before failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) a DECOMPENSATED LIVER DISEASE 30 DAYS Due to (or es e consequence of): b. HEPATITIS CHRONIC 20 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequenca of): Due to (or as a consequenca of) rasulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other stgnfftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably ★ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes XX No 1 ☐ Yes 2 ☐ No

**Physician** Examiner

**Physician** 

/Medical

10a. Stata

Directo

Funeral

þ

Completed

Be

To

Examiner

**Funeral** 

**Director** 

item 27 is marked other than "natural", or items 23a or other traumatic avent, the Medical Examiner must be re

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumetic avent, the Medical Examinat

Baltimore, Maryland 21215-0020

Box 68760. deeth certificate be

P.0.

Division of Vital Records,

with the Maryland r 28a-f show

death

attending physician and for use es the burial-tran ed by the a 8 pege 2 director, funeral

Examiner

25. Was case referred to medical examiner? 27, Manner of Death

1□ Yes XXNo

XXNetural

2 Accident

3 Suicide

29a. Certifier

4 Homicida

(Check only one)

29b. Signature and title of ceptile

Physician/Medical þ Completed Be 10

6

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To the ! within 2

> State Registrar

edical

Certification:

has

certificata Physician:

After this

or Attending

Hospital 24 hours

death.

after death

31. Dete filed (Month, Day, Year)
DEC 29

10

5 Pending

invastigation

6 ☐ Could not be determined

NELSON P. TRUJILLO, M.D.,

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Hospital:

28a. Date of Injury (Month, Dey Year)

29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 24, 1998 D10656 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 2021 K STREET, NW, WASHINGTON, D.C. 20006 32. Registrar's Signature

1 Yes 2 No

28c. Injury at Work?

XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

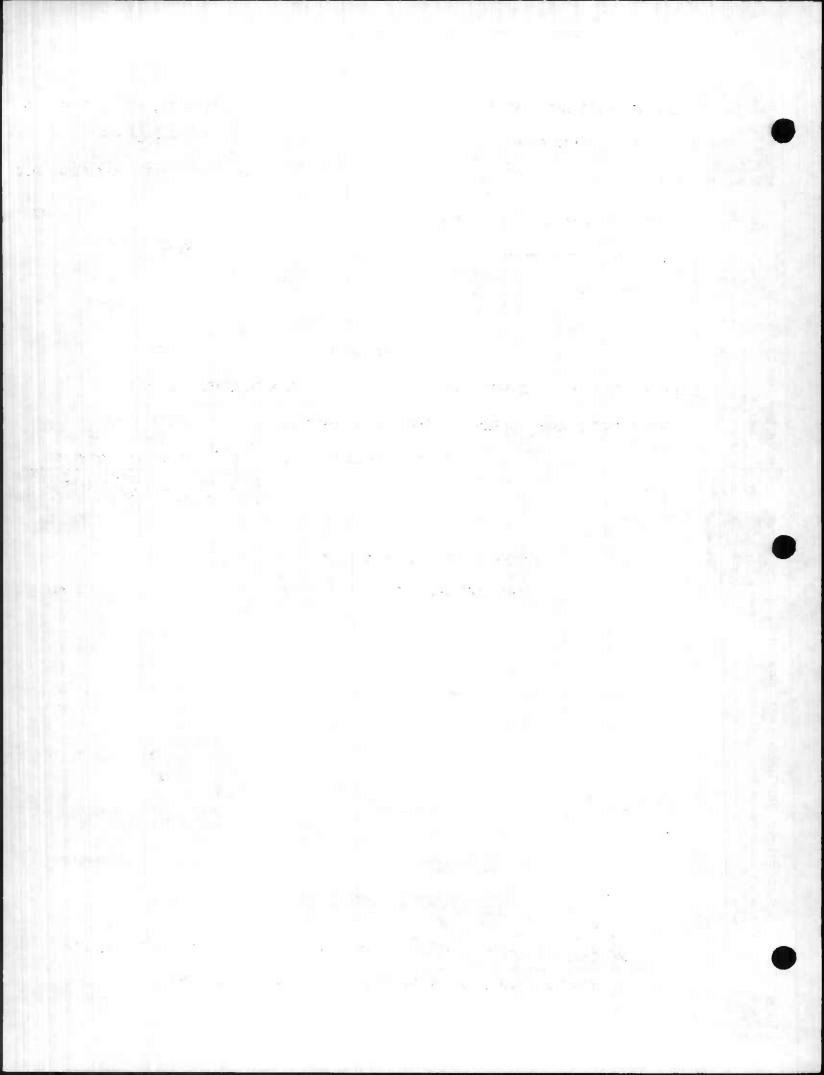
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated.

26. Place of Death (Check only one)

Other: 4 Nursing Home Residence 6 Other (Specify)

28d. Describe how injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, Stete)



State of Maryland / Department of Health and Mental Hygiene 8

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	Cortificate	of	Death	

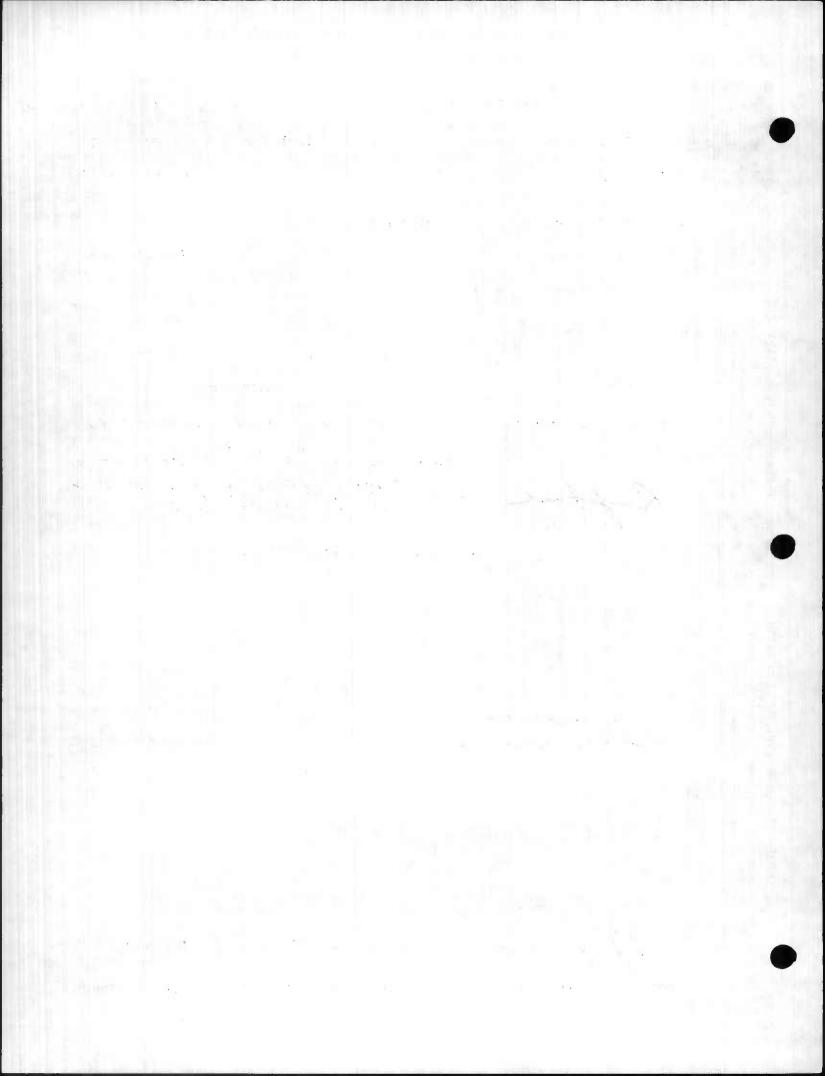
					Ce	rtifica	te of	Death		Reg. No.		
	1. Decedent's Nam	ne (First, Middle, Last,	)						2. Dete of De Month	eth Day	Year	3. Time of Death
Physician		Mur	iel Sue	Levin	e					er 28,		11:37 AM
/Medical   Examiner	4a Facility Name (	If not Institution, give	street and numb	er)				4b. City, Town, or I	_		y of Death	
	723 Wil	son Avenue						Rockvil1	Le	Mont	gome	ry
Funeral	5. Sociel Security N			Age (In yrs.	last birthday)		er 1 Year		8. Date of Bir	th Veerl	9. Birth	place (State or Foreign
irector	158-16-21 Usual Residence of	116	M 28 F	74	Yrs.	Months	Deys	Hours Min.	8. Date of Bir (Month, Da July 18	1924	New	place (State or Foreigntry) York
show stat	10a. State	10b. County		10c. Cit	y, Town or Lo	cation					T	10d. Inside City Limita
to to	Maryland	Montgome	rv	R	ockvi1	1e						1⊠Yes 2□No
recto	10e. Street and Nu		- )				ip Code			10g. Citizen of	What Cou	ntry?
rai Di	723 Wils	son Avenue					20	850		United	Stat	es
unera	11. Maritei Stetus		12. Wes Decede	nt Ever in U.	S. 13.	Wes Dec	edent of I	Hispenic Orlgin? (S	pecify Yes or No			can Indian,
by Funeral Director		ied 2 Married	Armed Force 1 Yes 2 if Yes, Give Yeer or Dete	s? ⊠No		If Yes, sp 1 ☐ Yes		Hispenic Orlgin? (Span, Mexican, Puerto Specify:	o Rican, etc.)	Special Special	ick, White, by: Wh	etc. nite
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Be Completed		cify only highest grad		F · \	(Give	kind of w	vork done use retire	during most of world)	king			
E O	Elementery/Seco	ondary (0-12)	College (1-4	01 5+)	So	cial	Wor	ker		Chestn	ut Lo	odge
O	17. Father's Neme	(First, Middle, Last)						18. Mother's Nen	ne (First, Middle	, Maiden Suma	me)	
ToB	David H	Parker						Theres	a Sacks			
-	19a. Informant's N	ame/Relationship (Ty	rpe. Print)		19b. Melli	na Addre	ss (Stree	t and Number or Ru	ral Route Numb	er, City or Town	n, State, Zij	o Code)
6		Levine/Hus						enue, Roc				
any injury or other traumatic event, trainiones.  To Be Compi	20a. Method of Dis			20b. P	Name of Dispo	noition (A)	ama at			20c. Location		
8	1 █ Burial 2	☐ Cremation 3 ☐ F	Removal from Ste	,,,				Dec. 31,	1998	0.1		
Con Con		5 ☐ Other (Specify)		No	rbeck					Olney,		
any in	21. Signeture of Fe	Jervice License	<del></del>	M001	98 R	bert 00 W	A. est	Pumphrey Montgomer	Funeral y Ayenu	Home/R	Rockv:	ille, Inc.
	23a. Part1, Enter	ne diseese, or compleant failure. List only or	ications that cau	sed the deat	h. Do not en	ter the mo	ode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate interval Between
cian	SHOOK, OF THE	art randre. List only of	10 00000 011 000	······································								Onset and Death
fical	Immediate Cause disease or condition	(Final	Can	cinom	a of t	he A	mpu1	la of Vat	er			2 years
ner	resulting in death)	211	3		or as a conse		-					z yeare
اةِ ا				Due to (c	1 as a conse	querica oi	· /-					
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edical	Cause (Disease or that initiated event	injury	D	Due to /o		wence of	١٠					
ed i	resulting in death)			Due to (o	r es a consec	quence or	):					
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be dateched for us by Physician/	Part II, Other signi	ficant conditions cor	itributing to deat	n but net res	uiting in the t	inderlying	cause g	iven in Part I.				to the cause of death
P date	Coronar	y Artery	Disease						1111	108 23UNO	3 Pro	bebly 4 Unknow
og p	Onthon	botio H	h d	Chara	- 4 -				24a Wes	an autopsy	24b. W	Vere autopsy findings
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a2s											of	i death?
director, paga 2									10	Yes 200 No	- 1	☐ Yes 2☐ No
Be	25. Was case reference examiner?	-						26. Place of Dea	ath (Check only	one)		
	1 Ty Yes 2□	No	lospital: 1 ☐ Inp		ER/Outpatie	nt 3 🗆 🛭	JOA		lome 5 🔯 Resi	idence 6 □Ot	ther (Speci	ity)
funaral flon:	27. Manner of Deal	th 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	đ.	28c. Inju	ary at ork?	28d. Describe	how injury occu	irred	
ha t	2 Accident	investigation				M	10	Yes 2 No				
completely filled in by the funers  Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pleca of building,	Injury - At he etc. (Specif	ome, farm, st y)	reet, facto	ory, office		28f. Location ( City or To	(Street and Num wn, State)	aber or Rui	ral Route Number,
Completely filled	29a. Certifier	12 Certifying Phys										
oleta Sdic	(Check only one)	2 Medical Examin	ner: On the basis and manner	s of examina stated.	tion and/or in	vestigatio	on, in my	opinion, death occu	rred at the time,	date and place	, and due !	to the cause(s)
M M	29b. Signature and	title of certifier	- 1			2	9c. Licen	se number		29d. Date sign	ed (Month	, Day, Year)
	X > /	2-11. 1	E. R	me	1 not		DO	9680		Decemb	er 28	3, 1998
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State Registrar

31. Date filed (Month, Day, Year) DEC 3 0 1998

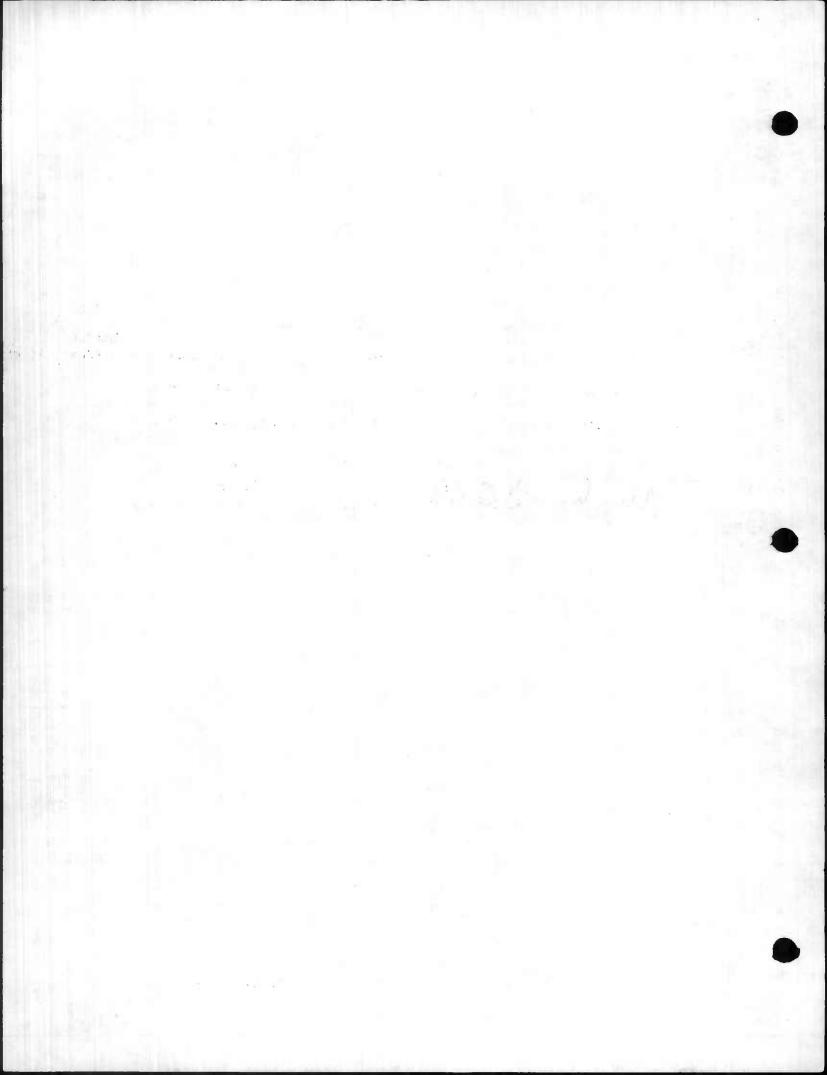
Joseph A. Romeo, M.D.

5454 Wisconsin Avenue, Chevy Chase, Maryland



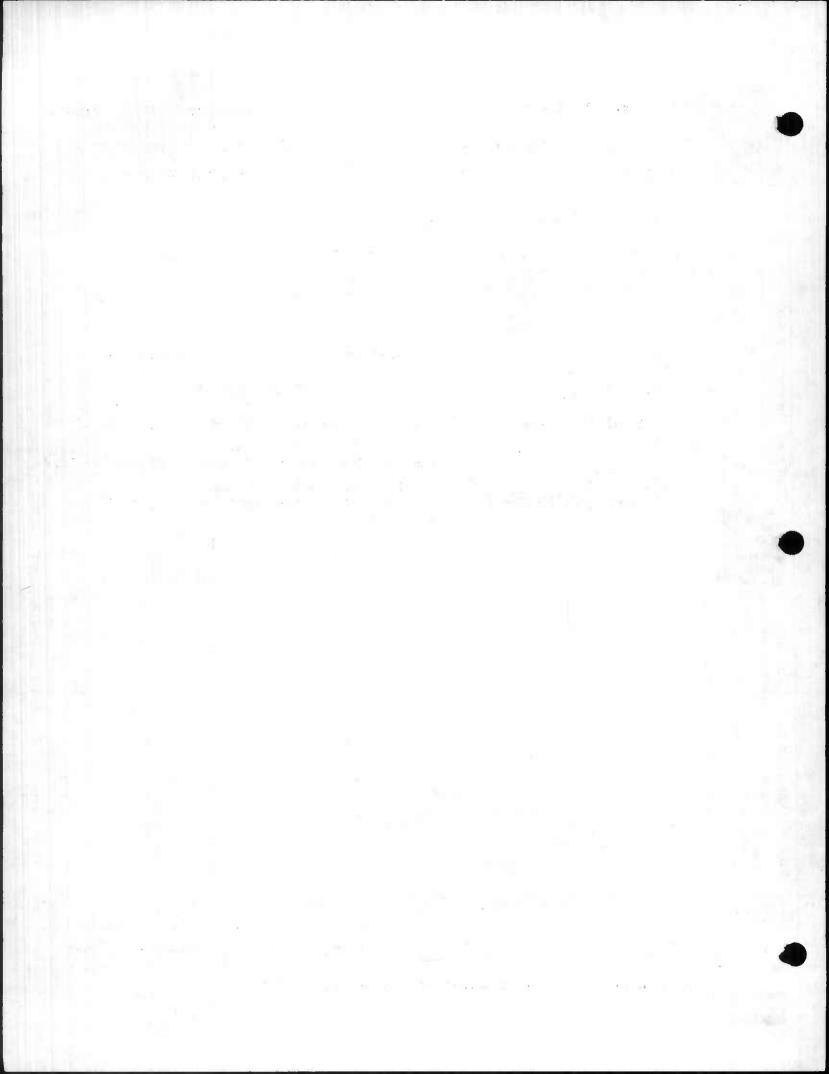
State of Maryland / Department of Health and Mental Hygiene 8 4 1 3 2 8

2011022			Certificate of	Death	Reg	a. No.	91020
Dhusisian	1. Decedent's Name (First, Middle, Last)				2. Data of Death Month	Dey Yea	3. Tima of Death
Physician /Medical	Joan Law	norne Lew	allen		December	19, 199	8 11:50 P.M
Examiner	4a Facility Name (If not institution, giva street			4b. City, Town, or Loc	cation of Death	4c. County of De	
	Suburban Hospital			Bethesda		Montgom	
neral ector	5. Social Security Number 220–40–4086  Usual Residence of Decedent	7. Aga (In yrs. la:	Months Days	Hours Min.	8. Data of Birth (Month, Day, ) March 1,	4011	irthplace (Stata or Foraign Country) aryland
	10a. Stata 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Director	Maryland Montgomery		Gaithersburg		100	g. Citizen of What (	1 ⊠Yes 2 □ No
by Funeral Director				0.77			
978	127 Water Street  11. Merital Status 12. W	as Decedent Evar in U.S.		877 Hispanic Origin? (Spe		nited Sta	ates nerican Indien.
by Funeral	1 Never Married 2 Married 1	med Forces? □ Yas 2 ☑ No Yas, Giva aar or Datas:	If Yas, specify Cut  1☐ Yes 2☑ No	oan, Mexican, Puarto F	Rican, atc.)	Black, Wr Specify:	White
2	15. Decedent's Education		16a. Decedent's Usual Occu	pation	16	6b. Kind of Busines	
Completed	(Specify only highast grada com Elementary/Secondary (0-12)	pleted) bllege (1-4or 5+)	(Giva kind of work done lifa. DO NOT use retire	i during most of work in ed)	9		National
PO	12	J. 100 (1 461 61)	Collator		Bu	reau of	Affairs
8	17. Father's Name (First, Middle, Last)			18. Mothar's Nama	(First, Middle, Ma	aiden Surname)	
To	Clarence Edv	ward Lawhor	ne		Helen	Flovd	
-	19a. Informant's Neme/Ralationship (Type, P.		19b. Mailing Address (Stree	t and Number or Rura			, Zip Code)
	Kenneth O. Lewallen/H	ushand	127 Water St	reet Cait	harchurg	MD 208	877
	20a. Mathod of Disposition	20b. Pla	ce of Disposition (Name of			Dc. Location - City	
	1 ⊠ Burial 2 □ Cremation 3 □ Remov	at from Stata	natery, crematory or other pla				
	4 Donation 5 Other (Specify)	Quan	tico National		1/24/98	Quantico,	Virginia
To Be Comp	ature of Funeral Service Licensee	1000	22. Nama end Addr	ass of Facility DeV	ol Funer	al Home	
	Muchan	1) Carlel	0 East De				MD. 20877
	23a. Part. Entar tha disease, or complication shock, or heart tailura. List only ona cau	s that caused tha daath.					Approximate Intervel Between
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	disease or condition resulting in death) a			1000	na o	+ 11ena	
5		Due to (or e	es a consequence of):			D 75-04	1
Examiner	b						
xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Dua to (or a	as a consequence of):				
	cause. Enter Underlying Cause (Disease or Injury						
edicai	that initiated events resulting in death) Last	Dua to (or a	s a consequence of):				
5	d						
Physician/					1		1
ys.	Part II. Other significant conditions contributions	ng to death but not rasult	ing In tha underlying cause g	iven in Part I.			ite to the cause of death?
£					1 🗆 Yes	2 No 3	Probably 4 Unknown
by							Man out
Completed					24a. Wes an performe		Were autopsy tindings available prior to completion of cause
9					,		of death?
0					1 Yes	2 No	1 Yes 2 No
	25. Was casa refarred to medical			26. Place of Death	(Check only one	)	
o Be	axaminer? 1)∑ Yes 2 No Hospite	el: 1 XInpatient 2 ☐ El	0 000	hor			
-			Proutpatient 3LI DOA	4 LI Nursing Hon	8d. Describe hov	ce 6 Other (Sp	респу)
Certification:	1 Natural 5 Pending	Month Day Year) 2	tnjury Wo		< 1.		ot self
cat	2 Accident invastigation 3 Suicide 6 Could not be	119198 1	MAKNOWN	Yes 2 No	200		
E	4 Homicide determined 28	<ol> <li>Place of Injury - At hom building, etc. (Specify)</li> </ol>	a, farm, street, factory, office	201	City or Town,	Stata)	Rural Routa Number,
S		ome: 1	27 Water	rs Stree	t ba	1 thers	ours, Md.
edical	(Check only 20) Medical Examiner: 0		edge, death occurred at the t n and/or investigation, in my				
×	29b. Signature and title of certifier		29c. Licen	se number	29	d. Date signed (Mo	nth, Day, Year)
	NO. T	MM	0.	C.M.E.	De	ecember 2	0, 1998
	J. Ferrance	11-10.					
	30. Nama and address of person who complet	1					
	Joseph Res	staner	111 Penn Str	eet, Balti	more, Ma	aryland 2	1201
State	31. Data filed (Month, Day, Year)	32. Registrer's Signetu	re 4 /	1,			
gistrar	DEC 28 1998	Alexen	B. Spark	2			



State of Maryland / Department of Health and Mental Hygiene 98 4 329

									Death			Reg. No.			
		1. Decedent'a Name (First, Middl	le, Last)								2. Date of De	ath	V	3. Tin	ne of Death
ysicia: Medica	_	Helen H. Li	ving	ston							Month Decemb	er 25	Year L 9 9 8	7:0	00 AM
viedica amine	er	4a. Facility Name (If not institution	n, give st	treet and numb		The					cation of Deat	4c. Cour	ity of Deat	h	JO AN
erai		Shady Grove Adv 5. Social Security Number 579—10—5116	6. Sex			last birthday	y) If Unde Months	r 1 Year Days		24 Hrs. Min.	B. Date of Bir (Month, Da Feb • 25	th ly, Year)	9. Birti	ery hplace (St untry) York	ate or Fore
	-	Usuai Residence of Decedent									100.23	,1707	TIEM	TOLK	, 14.1
18 Da	or	10a. State 10b. County				ty, Town or I									de City Lim
north	Y 1	Maryland   Montg	omer	У	RC	ckvil		p Code				10g. Citizen o	4 Minet Co	A	(
untbe		1235 Potomac Va	11ey	Road				0850				U.S.		unityr	
Exar	by Funeral	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	ried	2. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? XNo	J,S. 13	if Yes, spe				ecify Yes or No Rican, etc.)	Spec	ace - Ameriack, White		n,
Medical	Completed	15. Deceden (Specify only highe	nt's Educa	ation com <i>pleted)</i>		18a. Dec	edent's Usu ve kind of wo	ai Occu	pation during mos	t of worki	ng	16b. Kind of	Buainess/I	Industry	
N N	du	Elementery/Secondary (0-12)		College (1-4	or 5+)										
i i		17. Father's Name (First, Middle,	Last)			Adı	minist	rat	1	er's Name	(First, Middle		intin	g	
	m	Samuel Mindel								ice			211107		
traumatic	2	19a. Informant's Name/Relations		a Print)		19b Mei	ilina Addres	s (Stree			Gande		m State 7	in Code)	
trac	-1	Saul Mindel / B									Silver				5
retho	-	20a. Method of Disposition	1001		20b. l	Piace of Disp	position (Na	me of		1	Date	20c. Location			
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any Injury or c		21. Social of a salvica	Censue	1					ess of Facili		al Home				
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		23a. Part1. Enter the disease, or shock, or neart failure. List	complica	ations that cau	sed the dear	th. Do not e	nter the mo	de of dy	ing such as	cardino c		renet		Approx	imate
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 3100 FM LONCKE acembe CARMELLIA JOUISE 24 /Medical 4b. City. Town, or Location of Deeth 4e Feclity Name (If not institution, give street and number) 4c. County of Death Examiner ADVENTIST HOSPITAL SHADY GROVE ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Dey, Year) Apr 5, 1914 7. Age (In yrs. lest birthdey) 84 Yrs. 5. Sociel Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 20F Months Deys Hours Min. 132-09-9464 Jamaica Director Usual Residence of Decedent the Marylend r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩Yes 2 No North Potomac Directo ЬM Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Example must be in once. 15828 Seurat Drive U.S.A. 20878 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus Bleck, White, etc. 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: Black g 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 Yrs Elementery/Secondary (0-12) Office Secretary 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Joseph 0 A. King Isadora L. Dawson 19e. Informent's Neme/Reletionship (Type Darughter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15828 Seurat Dr, N. Potomac, Md 20878 Linda E. Lightfoot 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/3/99 New Haven, Conn Key,s Funeral Home ture of Funeral Service Licenses 22. Name end Address of Fecility Snowden Funeral Home P.A. 20850 tions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximately course on each line. Per Lenter the disclase, or complice shock, or heert feilure. List only or Approximate Interval Between Onset and Death **Physician** Chronic Postwetwe pulmonary desease /Medical Immediate Cause (Finel disease or condition resulting in deeth) ears Examiner Physician/Medical Examiner ettending physician end lor use as the burial-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Due to (or as e consequence of) signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 12 Yee 2 No 3 Probably 4 Unknown recument à 8 24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy performed? should Completed peen a completion of cause of deeth? page 2 s has The 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete Physician: 25. Was cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 24 hours after deeth.

Funeral Director: After this funeral 27 Menner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? or Attending 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 T Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) à 4 Homicide Hospital 1 > Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29e. Certifier npletely (Check only one) within 2. To the F 4 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifin 29c. License number 0

State Registrar

31. Date filed (Month, Dey, Year)
DEC 3 1

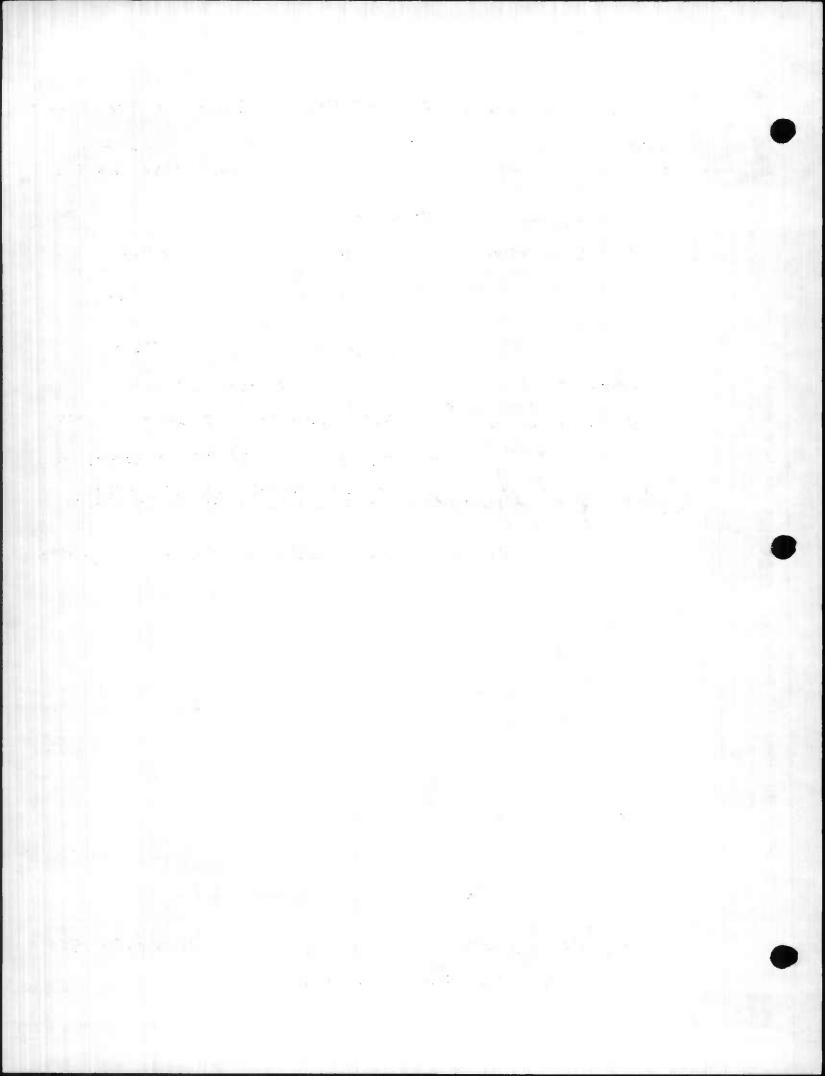
ALAN I. CHANALES

32. Registrer's Signeture Lever

30. Neme and eddress of person who completed ceuse of deeth (item 23e) (Type, Print)

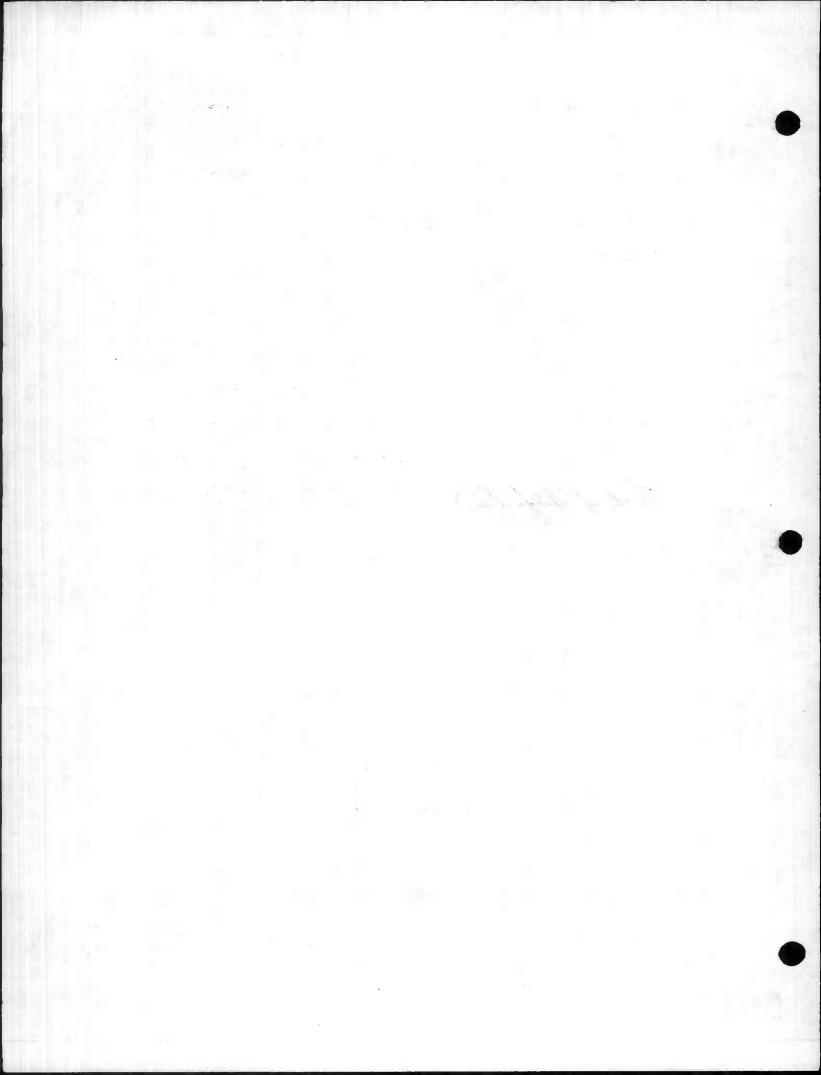
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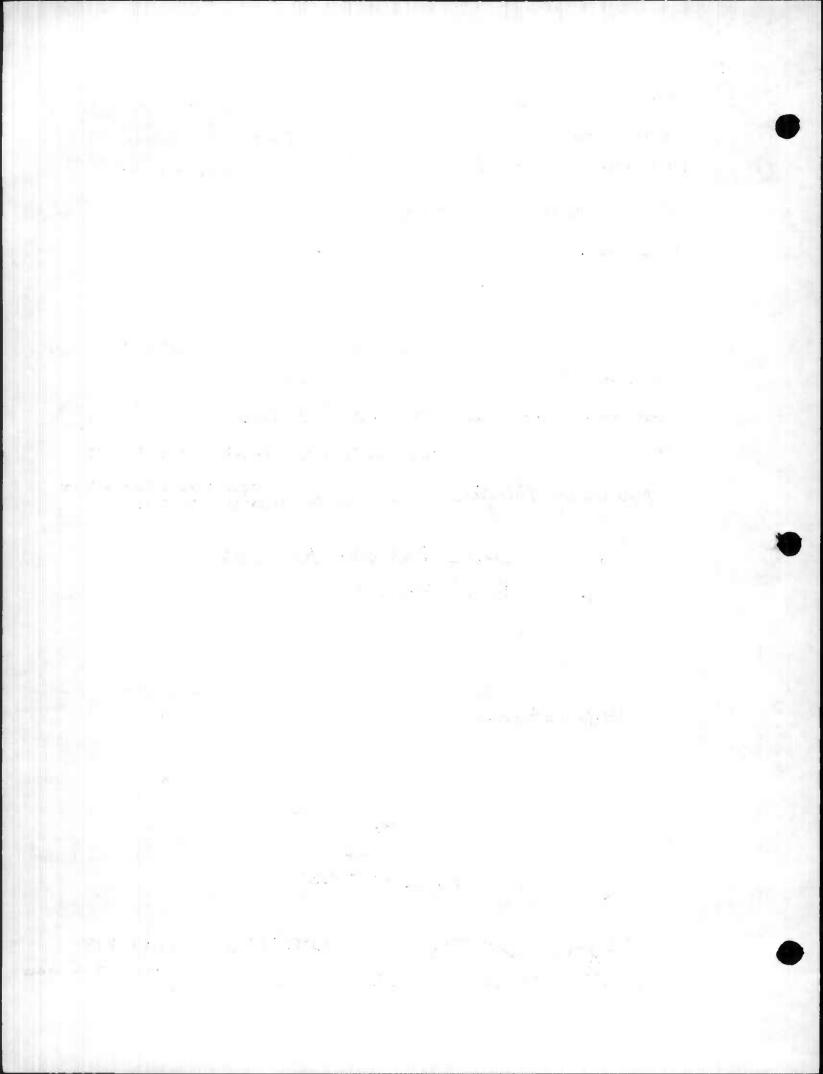
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

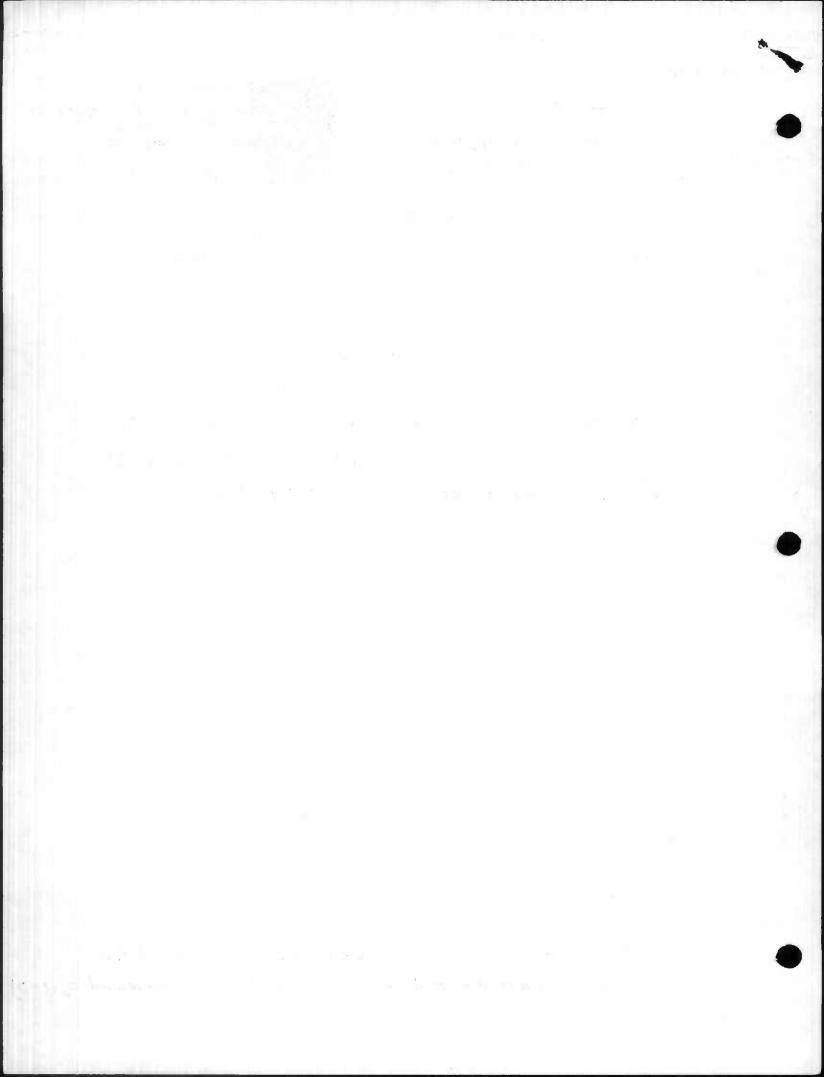
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tamir	ner	4e. Facility Name (If not Institution	, giva street end num	ber)			4b. City, Town, or	Location of Daar	th 4c. County	of Death	
_		Heron Point	0.0			H Haday 4 Vans	Chestert			Kent	
neral ector		5. Sociel Sacurity Number 215-16-8959 Usual Rasidence of Decedant	6. Sex 1 □ M 2 🔀 F	. Aga (In yrs	Yrs.	Months Deys			rth ay, Year) 1, 1915	9. Birthpia Country Mary	ca (State or Foreign v) Land
be notified at		10e. Stata 10b. County		10c. C	ity, Town or Loc	ation				100	f. Insida City Limits
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משמע כי אונטנונט בא טפומניופט וכי חאפ מפ	Physician/M	resuming in death) Last		Dua to (d	or es e c <i>ons</i> eque	ance of):	van in Psrt i.	1 🗆	Yes 20 No an autopsy ormed?	3 Probal	autopsy tindings abla prior to lation of cause ath?
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/Medi Examir		4e. Fecility Neme (I Lorien N	fnot Institution, giv Nursing C		m <i>ber</i> )			4b. City, To		ocation of Dee	1	ty of Deeth	_
Funeral Director		5. Social Security N 111-32-19	971	Sex 1□M 2∏ F	7. Age (In yrs. 99	last birthday) Yrs.	If Under 1 Ye Months De		Min.	8. Dete of Bi (Month, D Jan 18	rth ey, Yeer) 8 1899	9. Birth Cou MD	plece (Stete or For intry)
28a-f show	or	Usuel Residence of 10a. Stete Md	Decedent 10b. County Howa	rd		y, Town or Lo	ocation	49-11-12					10d. Inside City Lir 1 ☐ Yes 2 【
	Direct	10e. Street and Nur 10045 Gu	mber uilford R	oad			10f. Zip Cod	794			10g. Citizen of	Whet Cou	
it of Health end Mental Hygiene. If item 27 is marked other than "natural", or items 23s or other treumstic svent, the Med cal Examiner must be or other treumstic svent, the Med cal Examiner.	by Funeral Director	11. Maritel Stetus 1 □ Never Marri 3 ☑ Widowed	ied 2 Married	12. Was Dec Armed Fo 1  Yes If Yes, Gi Yeer or D	2 <b>]</b> () No ve	1	Wes Decedent of Yes, specify C	of Hispenic Or uben, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	o- 14. Re	eck, White	ican Indien, , etc. Lack
"netural".	eted	(Spec	15. Decedent's E	ducetion ade completed)		16e. Deced	dent's Usual Oc kind of work do DO NOT use rei	cupation ne during mos	st of work	ing	16b. Kind of	Business/Ir	ndustry
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h end Mental Hygie Is marked other t Iraumetic svent, to	To Be C	17. Fether's Neme		)				18. Moth Lean		e (First, Middle	, Meiden Sume	me)	
Department of Health and Mental Hygi important: If Item 27 Is marked other any injury or other traumatic svent. I once.		19a. Informant's Na Albert I	ame/Relationship (		hew)	19b. Mailir 10045	ng Address (Str	eet end Numb	Jes	sup, MD	per, City or Town	n, Stete, Zi	p Code)
nent of Health nt: If Item 27 iry or other tr	4	20a. Method of Disp	oosition Cremation 3 5	Removal from	State Bu	lece of Dispo emetery, crest Shey P	esition (Neme of metory or other) ark Cem	etery	12-	Dete 31-98	20c. Location Cooksvi		
Department of Important: If it any injury or outce.		21. Signeture of Fu			det.		.O. Box		Ha				Chapel
nysician Medical xaminer	Examiner	Immediate Cause (dissess or condition resulting in death)  Sequentially list conif any, leading to impact the cause. Enter Under Cause (Disease or Cause)		. 5	Due to (or	Mex res a conseq Faul res e conseq	quence of):	Ac	ide	Sis			Interval Betwee Onset end Deet
physician s the burial	dica	cause. Enter Unde Ceuse (Diseese or thet initieted events resulting in deeth) L		C	Due to (or	es e conseq	uenca of):						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Paer December 21, 1998 **Physician** Mary Ann Kelling Markwell 2143 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not Institution, give street and number) **Examiner** 6705 Rockledge Drive Bethesda Montgomery If Undar 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) September 30, 1948 5. Sociel Security Numbar 7. Age (In yrs. last birthday) 9. Birthpiaca (State or Foraign **Funeral** Days Months Hours 1 □ M 2 1 F Ohio Yrs 273-46-7817 50 Director Usuel Residence ot Decedent the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23e or 28e-f ahor must be notified at 1 Tyas 25 No Maryland Montgomery Bethesda Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 4977 Battery Lane, #512 20814 United States deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give r than "natural", or flame the Medical Examiner m Was Decedant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ₺ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) Coilege (1-4or 5+) Hygiene. 5+ Health Science Administrator 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be facent of Heelth end Mental I int: If Itam 27 is marked or Aloysius Kelling Lucille Neumann 19a. intormant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Gary Diamond/Personal Rep. 2815 University Blvd.W., Kensington, MD 20895 20b. Piece of Disposition (Name of cematery, cremetory or other plece) December 30, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ØCremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 22. Name end Address of Facility Robert A. Pumphrey Funeral Home/ethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, 21. Signature of Funeral Service Conse Bethesda-Chevy Chase, Inc. e disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical immediate Cause (Final Gunshot disease or condition resulting in deeth) seconds Examiner Examiner deeth certificate be executed physician and s the burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) attending pl signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 1 ☐ Yee þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed certificate has b irector, page 2 s 1 Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) To F Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Attending 1 Naturei 5 Pending December 21, 498 21-13 11-5

28e. Piece of Injury- At home, term, street, fectory, office building, etc. (Specify) inflicteg 1 Yes 2 No death. Unshot 2 Accident investigetion determined

28e. Piece of Injury: At home, term, street, fectory, office building, etc. (Specify)

City or Town Stete)

Certifying Physician: To the bests of examination and/or investigation in my opinion and manner stated. or Attan after deat Director: 3 Sulcide 4 ☐ Homicide 24 hours Medical 29a. Certifier To the I 29d. Data signed (Month, Day, Year) D51916

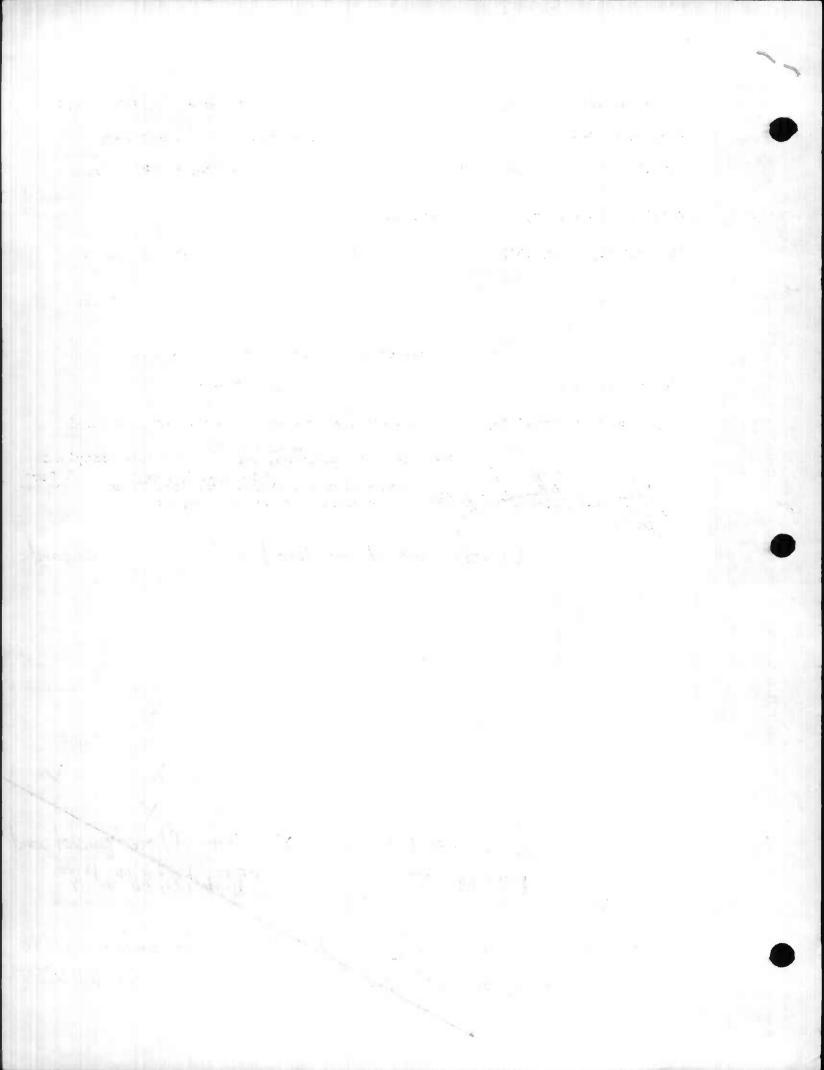
Rockville Pike,#348, Kockville, MD 20852

State Registrar 30. Neme end address of person who comp

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31. Date tiled (Month, Dey, Year)

Patricia

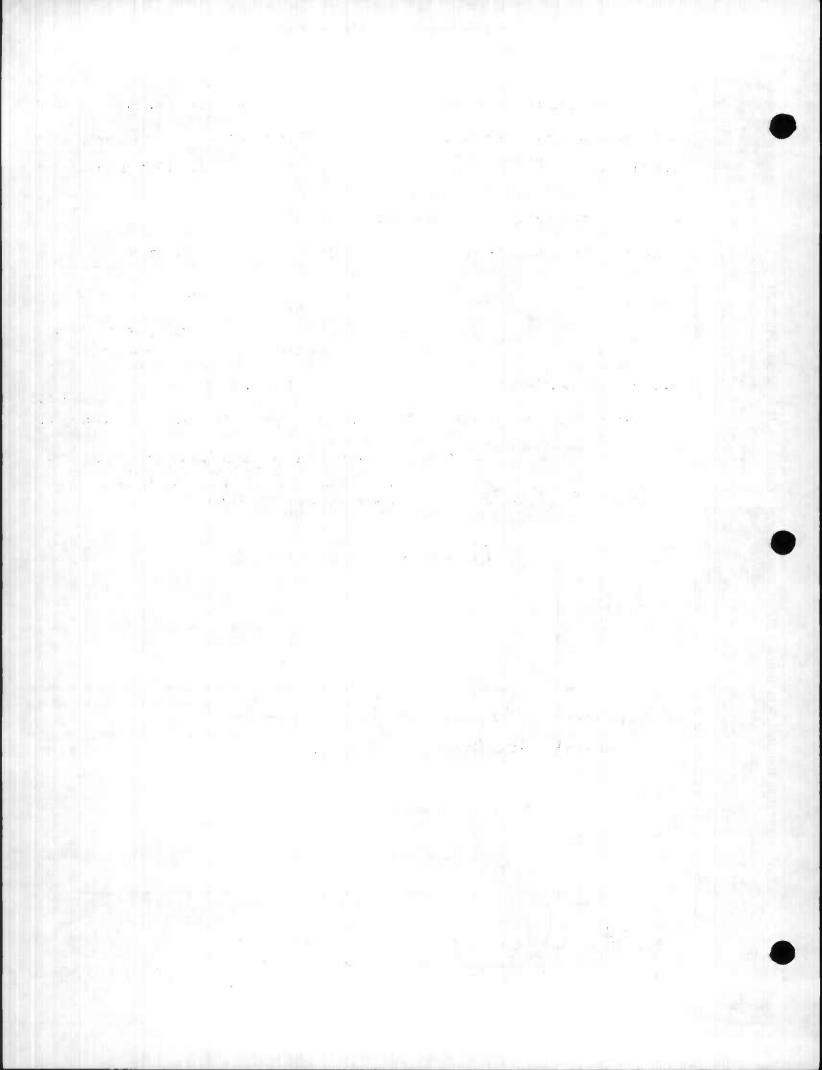


		Certificate of Death		Reg. No.		
ı	Physician		2. Deta of Do Month Decemb	eeth Day er 26, 1	Year 998	3. Time of Death 1:00 PM
\$	/Medical Examiner	4h City Town of				
		Washington Adventist Hospital Takoma		Mon	tgom	ery
Г	Funeral Director	5. Sociel Security Number 213-31-2121  6. Sex 123 M 2 F 7. Age (In yrs. lest birthdey) 45  Yrs.  6. Sex Nonths Deys Hours Min.	8. Deta of Bi (Month, D Oct. I	9, 1953	9. Birth	plece (State or Foreig ntry) Salvador
	P .	Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location				and to the Object has
	ehow ehow					10d. Insida City Limite 1 ☑ Yas 2 ☐ No
	th with the Maryler 23a or 28a-f show ust be notified at	MD Montgomery Chevy Chase  10e. Street and Number 10f. Zip Code		10g. Citizen of V	After a Court	
	with with	Total Street and Number				ntry r
	ne 23	3703 Chevy Chase Lake Drive, #1 20815  11. Meritel Status 12. Was Decedent Ever in U.S. 13. Was Dacedant of Hispanic Origin? (S	necify Yes or N	El Salv		can Indian,
020	W 0 = .	Armed Forcas? If Yes, specify Cuban, Mexican, Puert  1 Never Married 2 Married 1 Yes 2 No		Blac	ck, White,	
0-0	"natural", softes Exe	15. Decedent's Education (Specify only highast greda completed)  16a. Decedant's Usuel Occupetion (Give kind of work dona during most of work dona	rt inn	16b. Kind of Br		
21215-0020	ges 1 and 2 should be filed within 72 hours t of Health and Mental Hygiene. If item 27 is marked other than "natural", or other treumatic event, the Medical Exa To Be Completed by	3 Widowed 4 Divorced Specify: E1  15. Decedent's Education (Specify only highast greda completed)  Elementery/Secondery (0-12)  Collega (1-4or 5+)  2 Maintenance Engineer	King	Montgom	ery ools	County
	be filed d other event,	17. Fether's Neme (First, Middle, Last)  18. Mother's Ner	me (First, Middle	e, Meiden Sumer	10)	
Maryland	Mental Mental arked o atic events	o Miguel Angel Martinez Felip	a Torre			
lan	2 should end Men is marke eumatic	19e. Informant's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Ru	urel Route Numb	ber, Cify or Town,	Stete, Zip	Code) 20815
	1 end Health em 27 other tr	Anna Gloria Martinez (wife) 3703 Chevy Chase Lake		_		
Baltimore,	permit. Peges 1 end Department of Health Important: If Item 27 any injury or other th once.	20e. Method of Disposition  1  Burlel 2 Cremetion 3 Removel from Stete  4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of camatery, cremetory or other place)  Gate of Heaven Cemetery	Dete 12/30/98	20c. Location -		
Balt	permit. Peges Department of Important: If it any injury or o	21. Signatur of Funaral Sarvice Licensaa 22. Nama and Addrass of Fecility F Home, Inc. 500 Un Silver Spring, MD	rancis iversit 20901	J. Colli y Blvd.	ns F West	uneral
	ALC: U	23a. Pen . Enter the alleas, a complications thet caused the death. Do not enter the mode of dying, such as cerdied shock, or heart failure. Lint only one ceuse on each line.	or respiretory	errest,		Approximata Intervel Betwaan
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)  a. Core by al hemory hey	oe_			Onsat and Death
ŀ	nsit niner	Due to (or es e consequence of):				
60,	ifficate be executed g physician end es the buriel-transit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events  Due to (or as e consequence of):			t	
x 68760,						
Box	death certifies e ettending of for use e		1 200 000			
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Records,	law requires that as been signed be 2 should be detentionally be applicated by Pl	Renal Failure		s en eutopsy formed?	av cc	ere autopsy findings vailable prior to empletion of cause death?
	ician: The law certificate hes rector, page 2	0	10	Yas 2 XNo		□Yes 2□No
ta	entificat sclor, p	25. Was case referred to medical     26. Place of Dec.			1	
of Vital	Physician: this certific and director, TO Be	examiner?  Hospital:		sidence 8 🗆 Oth	ner (Speci	(y)
o uo	ith.  After this e funeral di		28d. Describe	how injury occur	red	
Division	if or Attending after death.  Director: After d in by the fune fune turk.	3 Sulcide 3 Sulcide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location City or To	(Street end Numb own, Stete)	ber or Rur	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.				
	To within	29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number	U	29d. Date signe	ed (Month,	Day, Year)
	13	30. Name and andre is of person who completed cause of deeth (Item 23e) (Type, Print) Dpinder, Singh		10		2 2 2

State Registrar

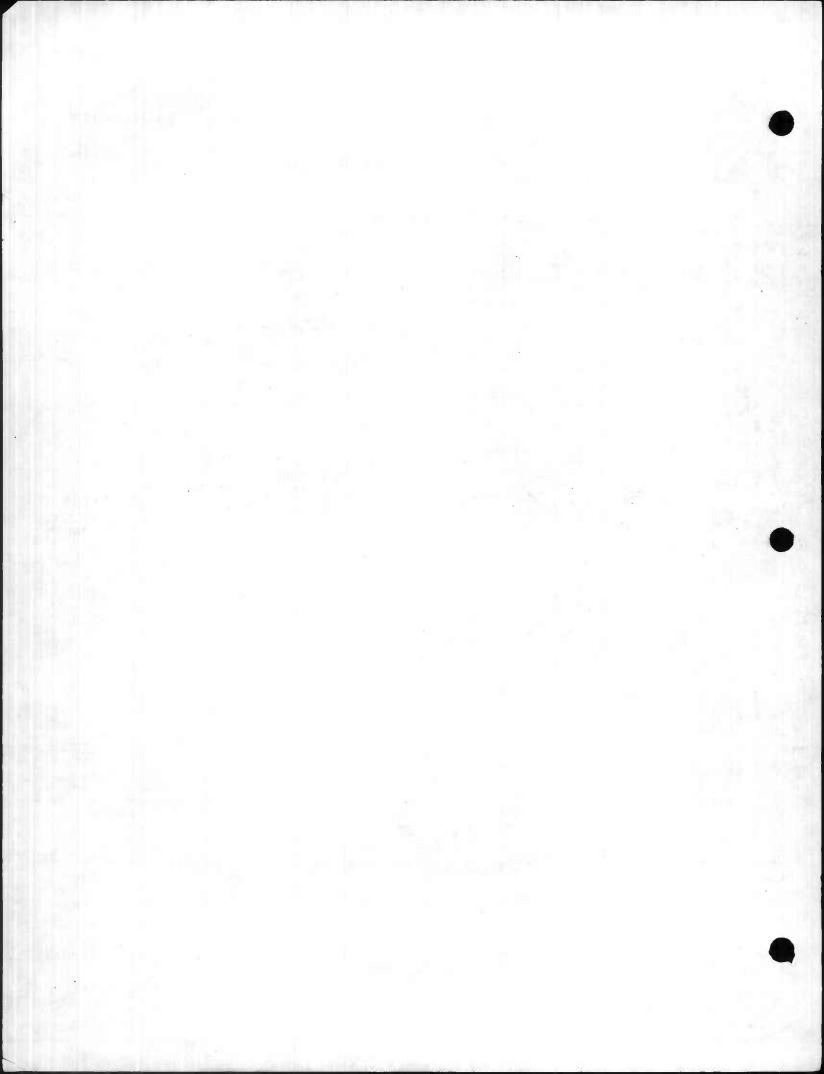
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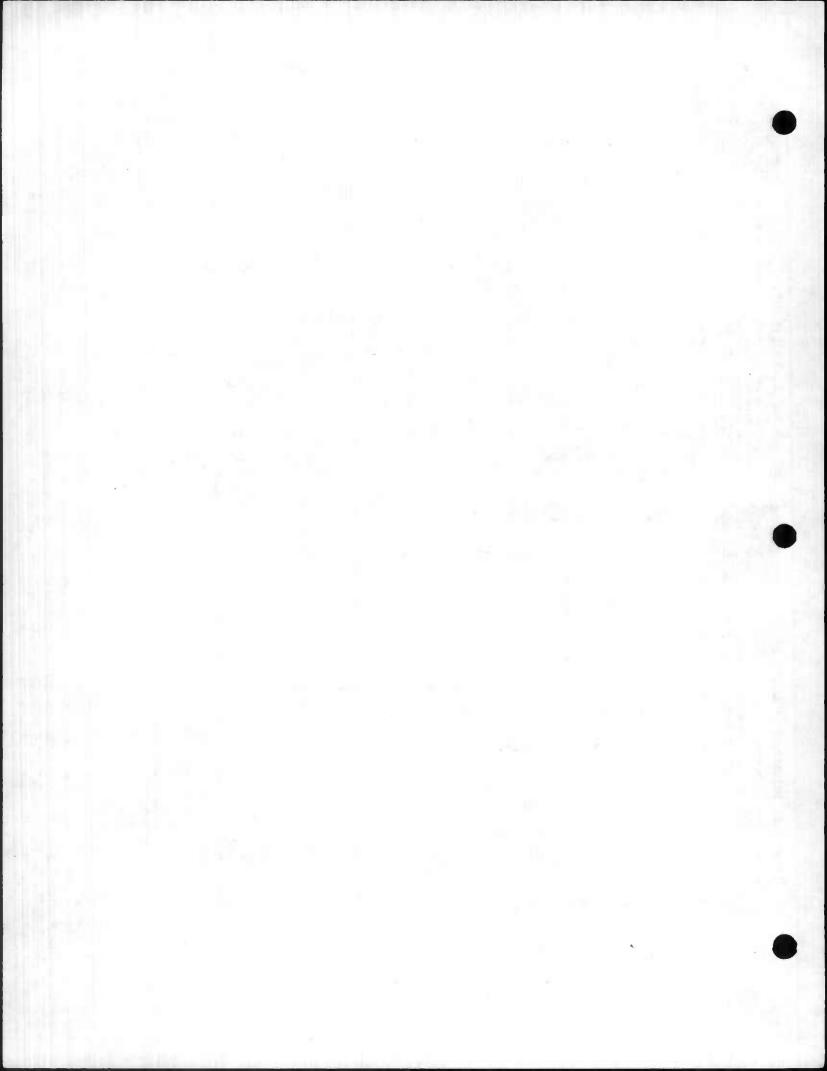
State of Maryland / Department of Health and Mental Hygiene

							Ce	rtifica	te of	Death		Reg. No.	17.	331	6
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)	Examine	er		(If not institution, gi		er)				4b. City, Town, or					
				an Hosp				Millada	1 V	Bethes		Mont	-		
	Funeral Director		5. Social Security  022-20 Usual Residence	-4001	Sex 7. 1□ M 21XF		9 Yrs.	Months	Days	Hours Min.	(Month, Da	y, Year) 3-1929	9. Birthp Coun Ma	lace (State o	or Foreign
	Pu de		10e. State	10b. County		10c. C	ity, Town or L	ocation					1	Dd. Inside C	ity Limits
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	Pod Pod	Director	10e. Street and No	umber		1		10i. Zi	p Code		_	10g. Citizen of V	Vhat Coun	try?	
	3a o		6210 R	ockhurst	Road			2	081	7		USA			
20		by Funeral		rried 2 Marned	12. Was Decede Armed Force 1  Yes 2 I If Yes, Give Year or Date	is? A No		Was Dece If Yes, spe		Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e - Americ k, White, White	etc.	9
3	hou			15. Decedent's E		o	16s Dece	dent's Usu	ial Occui	nation		16b. Kind of Bu	islness/inc	lustry	-
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2	H H	Be C	17. Father's Name	(First, Middle, Last		-03				18. Mother's Na	me (First, Middle,	Maiden Sumam	0)		
2	id be entai ked o ic ev	TOB	Peter	Kyne						Mary	E. Lyd	on			
2	should nd Men marke umarke		19a. Informant's I	Name/Relationship	Type, Print)		19b. Maili	ing Addres	s (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)	
Ē	and 2 paith a n 27 is nor tra		Chest	er Maze	( Husbar	nd)	6210	Roc	khu	rst Rd.	Bethe	sda, Mo	1. 2	0817	4
ע	A Her other		20a. Method of Di	sposition		20b.	Place of Dispo	osition (Na	une of	T	Date	20c. Location -			
2	Pages net: if he iry or o			2 ☐ Cremation 3 ☐ 5 ☐ Other (Special						School	12/24/	98 Wash	1. D	.C.	
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is mericed other than any injury or other traumatic event, the Health Bales.	1		uneral Service Lice		- GEC		2. Name a	nd Addr	ess of Facility		22.1			
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		1	23a. Part1. Ealer	ph disease, or com	plications that caul	the dea	ith. Do not en	8821 ter the mo	14t	h St, N	or respiratory a	sh, D.(	C. 2	O O 1 1 Approximat	te
F	Physician /Medical	1	Immediate Cause	(Final	one cause on each	n line.	AH	,						Interval Bet Onset and	Death
1	Examiner		disease or conditi resulting in death		8.	Due to /	or as a conse	anence of	١.				1		115
		ē				200 10 (	0. 43 4 00.130	quonou on	,.						
	tificate be executed go physician and as the burial-transit	Examine	Sequentially list c	conditions.	b	Due to (	or as e conse	quence of)	):				-	3 137	
5	a dan l		Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even	immediate denying									- 1		
	A Sic b	edica	that initiated even resulting in death)	or injury	C	Due to (	or as a consec	quence of):	:						
	5 0 0	-	rooding in ooding	Lust			25								
	death certifica attending ph d for use as th	Physician/N			d	7.77	1100								
	the at	200	Part II. Other sign	ificant conditions	contributing to death	but not re	sulting in the u	inderlying	cause gi	ven in Part I.	23b. Did	tobacco une cor	ntribute to	the causa	of death?
	et act	Ē									10	Yes 2 No	3 Prot	bably 4	Unknown
2		6													
	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for usa	Completed		* 691						10	24a. Was perio	an autopsy med?	ave	ere autopsy allable prior mpletion of o death?	to
	The law ate has page 2	E				With the	- 20				10	Yes 25 No	10	Yes 2	No
			25. Was case refe	erred to medical		• • • • • • • • • • • • • • • • • • • •	The second			26. Place of De	ath (Check only	one)	1		
	Physician: this certific ral director,	0	examiner?	No	Hospital: 1 ☐ Inpe	atient 2	ER/Outpatie	nt 350 D	OA Ot	her: 4 Nursing 1	Home 5 ☐ Resi	dence 6 □Oth	er (Specif	v)	
	ding Phys h. After this funeral di		27. Manner of Des		28a. Date of It	njury Dev Year)	28b. Time of	N I	28c. Inju	y at	28d. Describe	how injury occur	red		
5	Attanding ir death. ector: Afte by the fune	atio	1 Natural 2 Accident	5 Pending investigation		Day ( Dair)	Hijory	М		Yes 2□No					
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of	Injury - At h etc. (Speci	nome, farm, st	reet, factor	ry, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	i Route Nun	nber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)		nysician: To the be- niner: On the basis and manner	of examina									s)
	vithin omp	_	29b. Signature an	d title of certifier				29		se number		29d. Date signe	d (Month,	Day, Year)	
)	->-0		1/1/2	und Ho	rde a	0			PY	7791		December-	23.	1958	
	2	-	30. Nama and add	lress of person who			m 23a) (Tyne	Print)				14.	/	, , , ,	
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	State	9	31. Date filed (Mo			strar'a Sign	1	/	,						
			-	TA 0 0 40	00 1	a a desired	100	11/1	20- 4	. /					



State of Maryland / Department of Health and Mental Hygiene 8 4 3 3 7

				(	Certifica	te of	Death		Rec	a. No.		
		1. Decedent's Neme (First, Middle,	Last)						2. Date of Death			3. Time of Death
	Physician	Joseph	В.	McC	Cully			I	Month December	29, 1	998	8:35 PM
	/Medical Examiner	4a Facility Name (If not institution,	give street and number	)			4b. City, To		ation of Death	4c. County		
1	Examine	Montgomery Villa	ige and Reh	abilitat	ion		Monte	omery	Village	Monte	omer	v
Н	Funeral		. Sex 7. A	ge (In yrs. last birth	day) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birtho	place (Stete or Foreign
	Director	577-09-6039 Usual Residence of Decedent	12XM 2□ F	81 Y	S. Months	Days	Hours	Min.	(Month, Day, ) April 15	, 1917	Wash	hington, DC
	ylan	10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside City Limits
	Maria Maria	MD Montgo	omery	Mont	gomery	Vil	lage					1 ☐ Yes 2 No
	or 28s-f a	10e. Street and Number			10f. Z	p Code			10	g. Citizen of V	What Coun	itry?
	ter death with the Marylan terms 23s or 28s-f show the must be notified Funeral Director		Road, Apt.	314		208	86			U	SA	
	r thems 23	11. Maritel Status	12. Was Decedent Armed Forces	Ever in U,S.	13. Was Dece	edent of H	lispanic Ori	igin? (Spec	cify Yes or No- lican, etc.)		e - Americ	
Maryland 21215-0020	by I	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2		1□ Yes	25	Specify:				Whi	
2-0	ed within 72 hours ygiene. For then "natural", It, the Medical Ex-	15. Decedent's		16a. D	ecedent's Use Give kind of w	uat Occup	etion	et of workin	10	8b. Kind of Bu	usiness/Inc	dustry
7	within one.	Elementary/Secondary (0-12)	College (1-4or		ife. DO NOT	use retired	d)	t or works				
7	Hygien Hygien Con	10		Gen	neral E	orem				PEPCO		
P	ETEE .		st)				18. Mothe	er's Name	(First, Middle, Me	eiden Suman	10)	
yia	The Men						Na	ncy A	Abel			
Aar	M	19a. Informant'a Neme/Reletionship										Code) 20886
	Health Hem 27 other tr	Marie B. McCully	(wife	-			se Ro	ad, A				Village, MD
Ore	642	20a. Method of Disposition  1 Burial 2 Cremetion 3	☐Removel from State	20b. Place of E cemetery,	crematory or	other ple	ce)		Date 20	Dc. Location -	City or To	wn, State
E	Pages ment of ant: If Its ury or o	4 Donation 5 Other (Spe		Gate of								ng, MD
Baitimore,	pemit. Page Depertment of Important: If any Injury or page.	21. Signature of Funeral Service Lic	ensee						ncis J.			neral
00	89F 28	tours 1)	Zand I		Home, Silver	Inc.	500	MD 3	versity	Blvd.	West	
		23a. Part1. Enter the disease, or co	mplications that cause	d the death. Do no						st,	1	Approximate
я	Physician	shock, or heart feilure. List or	ly one cause on each	ine.								Interval Between Onset and Deeth
ч	/Medical	Immediate Cause (Final disease or condition	Metast	atic Rena	al Cell	Car	cinom	na				6 months
	Examiner	resulting in death)	a. Ticcasc	Due to (or as a co			CITOM	iu			1	o monens
	ž ž					,						
	certificate be executed being physician and see as the burlal-transit and burlal-transit by Medical Examiner	Sequentially list conditions,	b	Due to (or as a co	nsequence of	):						
0	EX EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated exerts.									i	
68760,	ficate be physicia as the bur edical	that initiated events resulting in death) Last	C	Due to (or as a co	nsequence of)	:					1	
	map land											
Вох	eath certification attending platfor use as 1 for use as 1 clan/Mec		d								1	
	at the death ce d by the attend fetached for us.  Physician/	Part II. Other significant conditions	contributing to death I	out not resulting in t	he underlying	cause giv	ven in Pert I		23b. Did tob	acco use co	ntributa 10	o the cause of death?
P.0.	ras that the designed by the a libe detached file by Physic	non insulin depe	ndont dich	otos moli	litua				1 🗆 Yes	2 No	3 Prol	bably 4X Unknown
	by by	Hon Insulin depe	indent diab	etes mer.	LILUS						1	
of Vitai Records,	been sign should be		110000						24a. Wes an			ere autopsy findinga ailable prior to
900	as be	Coronary artery	uisease					_				mpletion of cause death?
æ									1□ Yes	2 🖾 No	10	☐Yes 2☐ No
ta	certificate rector, pag	25. Was case referred to medical	T				26. Place	e of Death	(Check only one	)		
>	Physician: this certific ral director. : To Be (	axaminer? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outp	atient 3 D	OA OH	ver: 4EX.Nu	ursing Hor	ne 5 Residen	ice 6 Oth	er (Specif	y)
0	arthis neral d		28a. Date of Inj (Month, Da	ury 28b. Tir	ne of ury	28c. Injui Wor	y at	2	8d. Describe how	v injury occur	red	
0	ath. Ath	1 Natural 5 Pending 2 Accident Investigat		29 7 00.7	M		Yes 2□	No				
Division	Affe by the	3 Suicide 6 Could not determine	286, Place of In	jury - At home, fam ic. (Specify)	n, street, fecto	ry, office		2	8f. Location (Stre		oer or Rura	al Route Number,
ā	tal or Attending Physis attaches.  In Director: Attachis led in by the funeral di		odiang, o	to. (Opeany)						0.0.0		
	Hospi 4 hours Funer taly fill		Physician: To the best aminer: On the basis of and manner st	of examination and/								
	within 2 To the comple				29	c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)
		1006	200	mi		D	334	54	D	b	25 3	0 1998
	10+1	20 Name and address of some	o completed assure of		ma Brins					ccem		,
		30. Name and address of person wh		Seath (Item 23a) (1)		Rd	(	2	Cuilles	ma	208	-51
	State	31. Date filed (Month, Day, Year)		rer's Signature	, , , , , (	,	•					
	Registrar	DEC 3 1 1	000	was 1	9. 1.	200 4	1,					



4 6 . 4 . 11 . 11 . 11	45 A A 41 A 41			Ce	rtificate	OI	Dealn			Reg.	No.		T
1. Decedent's Nem		1000							2. Date of Month		Day	Year	3. Time of Death
Mary (		ne McKer					4h City To	own ort	Decen	- 7	29 <b>.</b> .	1998	1:05 PM
		iew Drive											
5. Sociel Security N		6. Sex	7. Age (In yrs	. last birthday	If Under 1		If Under	tsvi 24 Hrs.	8 Date of	Birth	Prince	9. Birtho	olace (State or Foreign
578-12-6	5923	1□M 2□ F	84	Yrs.	Months	Days	Hours	Min.	Nov.	DRV. YE	1914	Was	hington, D
Jsual Residence of Oa. State	Decedent 10b. County		100.0	a. Tain ast	e e e tien								04 1-14-05-11-5-
				ity, Town or L								1	1 ☐ Yes 2 ☑ No
MD 10e. Street and Nu		ce George	S	Beltsvi	.LLE	Code		_		100	Citizen of V	What Cour	
		iew Drive			1024	5000	207	0.5		109		JSA	
11. Meritel Stetus		12. Wes Dec	edent Ever in U	J,S. 13.	Was Decede	nt of H			ecify Yes or	No-	14. Rac	e - Americ	can Indian,
1 Never Marri	ied 2 Merrie		2 2 No		1 Yes, specif		an, Mexica Specify		Hican, etc.)			ck, Whita,	
3 🖾 Widowed	4 Divorced	If Yes, G Yeer or I			10 165 2	LZZ INO	эрвану				Specify	γ.	White
(Spec	15. Decedent'	's Education t grade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occup done	ation during mos	st of work	ing	16b	. Kind of B	usiness/în	dustry
Elementery/Seco	ondery (0-12)	College (	(1-4or 5+)	Teac		o retirec	"			300	Educa	tion	
17. Father's Name	(First, Middle, L			Teac	nei		18. Moth	er's Nam	e (First, Mid	dle, Maio			
John J.	Donnel1	Lan					Max	rv A	gnes M	ulha	11		
19a. Informant's Na	ame/Relationsh	nip (Type, Print)		19b. Mail	ing Address (	(Street						State, Zip	Code)
Denis D.	McKenn	na (so			6 Fore			Driv	ze, Be	ltsv	ille,	MD	20705
20a. Method of Disp		3 Removal from		Place of Disponentery, cre					Date		. Location -	-	
4 Donation	5 ☐ Other (Sp	ecify)	Ga	te of									ng, MD
21. Signature of Fu	ineral Service L	jeensee		2	2. Name and	Adden		in. Hims	ancis	J. C	ollin	is Fu	neral
				H									
23a. Pert1. Enter the shock, or hee	(Finel			S	lome, I	nc. Spr	500	Un:	lversi 20901	ty E	Blvd.		Approximate Interval Between Onset and Death
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State Registrar

Charles M. Benner, M.D., 11251 Lockwood Drive, Silver Spring, MD

31. Date filed (Month, Day, Year)

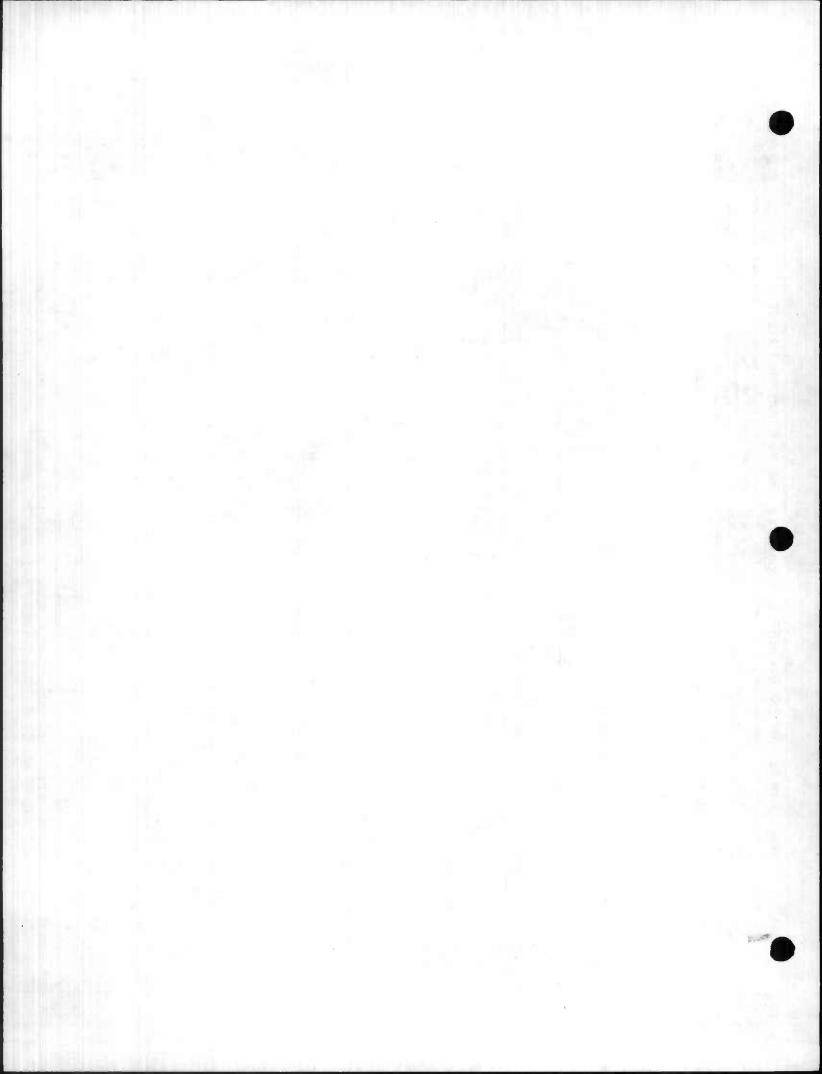
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32. Registre's Signeture

\$\mathcal{D}\$. \$\left(\frac{1}{2}\text{parts}\right)\$

Baltimore, Maryland 21215-0020

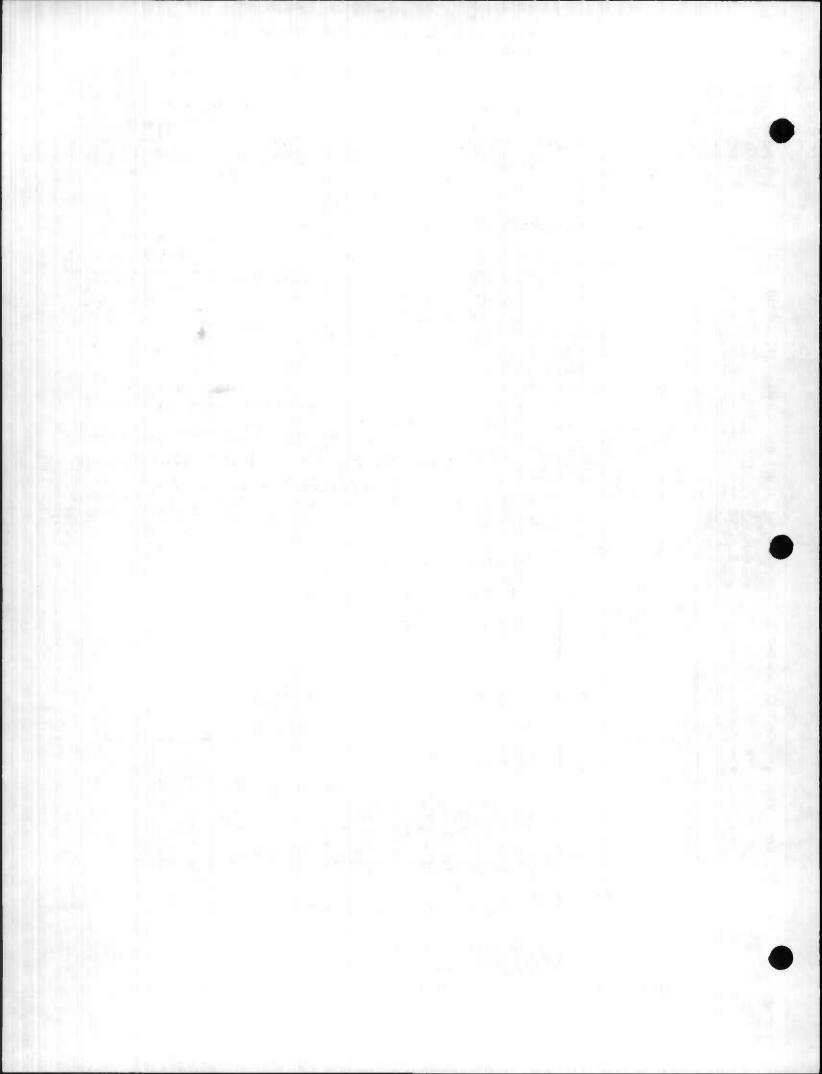
Division of Vital Records, P.O. Box 68760,



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 1 3 3 9

	Decedent's Nama (First, Middla, in the control of the control	act)		001111	ficate of	Death	2. Data of De	Reg. No.	3. Time of Death
Physician	1. Decedent's Nama (First, Middla, I		T	W411			Month		Yaar
/Medical	A. Farith Many III and Institution of	Martha	Jane	Mille	r	4b. City, Town, or I	Decembe		2.10 111
Examiner	4a Facility Nama (If not institution, g	the state of the s		,					
	Shady Grove Ad 5. Social Security Number 6				f Undar 1 Yaar	Rockville			omery
Funeral Director	211-14-7896 Usual Rasidance of Decedant	1□M 2∏F	78		lonths Days		8. Data of Bird (Month, Da May 2,	y, Year) 1920 P	9. Birthplace (State or Foral Country) ennsylvania
death with the Maryland The 23e or 28e-f show The notified at The state of the control of the co	10a. Stata 10b. County		10c. City	, Town or Locati	ion				10d. Inside City Limi 1 ☐ Yas 2 ☑ ↑
ect oct	Maryland Montgo	mery	D	amascus				40.00	
or 284-19 be notified	10e. Street and Number			4	10f. Zip Coda			10g. Citizen of W	
123 173	10615 Hunters C			2 142 111	20872			United S	
"natural", or forms 23a or 23a-f show motical Examiner must be modified at letted by Funeral Director	11. Marital Status  1 □ Navar Marriad 2 ☑ Marriad  3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forcas  1 Yas 2 7  ff Yas, Giva Yaar or Datas	?		S Decedant of the same of the	Hispanic Origin? (S pan, Maxican, Puart Specify:	pecify Yas of No o Rican, atc.)	Black Specify:	- Amarican Indian, c, Whita, atc.  White
2 B	15. Decedant's			16a. Deceden	t's Usual Occup	pation		16b. Kind of Bus	
	(Specify only highast ( Elementary/Secondary (0-12)	Collega (1-4or	5+)	(Giva kin	d of work dona NOT usa retire	during most of wor	king	Own Ho	
C it page	17. Fathar's Nama (First, Middia, La	4 et)		пошеша	Kel	18 Mothar's Nan	na /First Middle	Maiden Sumama	
ever Be									
J Men Tatic	David Harold			40h 44-111 4	Adams (Otros	Martha	Susan	Stouffer	
h and	19a. Informant's Name/Ralationship		1)			t and Number or Ru	rai Houta Numb	er, ony or rown, s	Siara, 210 Cooe)
Healt ther	H. George Miller 20a. Mathod of Disposition	(husb		Same			Data	20c Location - (	City or Town, Stata
o T of	1 ☐ Burial 2 ☑ Cramation 3	☐Ramoval from State	CI	ematary, cramat	ory or other ple				
tant:	4 Donation 5 Othar (Spe		Che	sapeake	-		2-30-98	Beltsvil.	le, Maryland
Department of Health and Mental Hygiens. Important: If item 27 is merked other than any injury or other traumatic event, the the once.  To Be Compi	21. Signature of Funaral Sarvice Lic	V. Kas	exp	Rap	-	ass of Facility ral Servi Avenue, S			20910
WEST.	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ceuse ly one cause on each	d the death line.	n. Do not antar t	ha moda of dyi	ing, such as cerdiad	or raspiratory a	rrast,	Approximata Interval Batween Onset and Death
hysician /Medical	Immediate Cause (Final disaasa or condition	Anoxio	Ence	ephalopa	thv				24 hours
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ine it		Pulmor	nary E	Edema					24 hours
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centificate has rector, page 2 Be Comp	25. Was case referred to medical					26. Place of Dea	ath (Check only o		
his centil direct	examiner? 1 ☐ Yes 2 ☐XNo	Hospital:	ient 2 🗆	ER/Outpatient	3 DOA Ot	hor	-	dance 6 □Otha	r (Specify)
	27. Manner of Death  1 Natural 5 Pending 2 Accident invastigat	28a. Date of Inj (Month, D		28b. Time of Injury	28c. Inju			how injury occurre	
th.  After this si funeral di		28a. Place of In	jury - At ho	oma, farm, straat	, factory, office		28f. Location ( City or To	Street and Numbe	er or Rural Routa Number,
after death.  Director: After thi Jin by the funeral  ertification: 7	3 Suicida 6 Could not determine	building, a	ic. (Spacify						
24 hours after death. 25 hours after death. Funeral Director: After thistaly filled in by the funeral dical Certification: 1	4 Homicide determine	building, a Physician: To the best aminer: On the basis o	of my know						nner as stated. Ind due to the cause(s)
within 24 hours after death.  To the Funeral Director: After completaly filled in by the fune fune Medical Certification	4 Homicide determine  25a. Certifier (Check only 2 Medical Ex	building, a	of my know		tigation, in my			date and place, a	
Virtin 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be	4 Homicide  25a. Certifier (Check only one)  4 Homicide  determine  determine  determine  determine	Physician: To the best aminer: On the basis and manner s	of my know of examinat tated.	A, M.	29c. Licen	opinion, death occu	rred at the time,	date and place, a 29d. Date signed	nd due to the cause(s)

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 1754 Eugene Patrick Moody 26, 1998 December /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yaar | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year)
August 10, 1932

9. Birthplace (State or Foreign Country)
North Carolina 5. Soclei Security Number 6. Sex **Funeral** Deys Min. Months 1⊠M 2□ F Hours 082-24-4948 66 Director Usual Rasidence of Decedant the Manyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "netural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Directo MD Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4907 Eastern Avenue, #212 20782 USA Funeral 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) Black, Whita, atc. 72 hours after 1 ⊠ Yes 2 □ No
If Yas, Giva
Year or Dates: Unknown 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nath any injury or other treumatic event, tra Medical page. 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Systems Programmer Analyst Computer 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Eugene Patrick Moody Julia Schmitt 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiane B. Moody (daughter) 8905 Barrowgate Court, Potomac, MD 20e. Mathod of Disposition 20b. Piece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriei 2 M Cramation 3 ☐ Ramovai from Stata Metropolitan Crematory 4 ☐ Donation 5 ☐ Othar (Specify) Alexandria, VA 1/2/98 22. Name and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funeral Service Licensee Home, Inc. 20901 tallher Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Between Onset and Daeth **Physician** Immediate Causa (Final diseesa or condition rasulting in deeth) /Medical Arteriosclerotic Cardiovascular Disease Examiner Due to (or as a consequence of): Examine physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 88 attending 987 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the the signed by to 1 | Yes 2 | No 3 | Probably 4 | Unknown by been si 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital Physician: Be 25. Was casa rafarred to medical 28. Placa of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 X Yes 2 □ No After this 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending invastigation 1 X Natural s after death.

I Director: Aft
d in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) OME, 6t D15236 December 29, 1998 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Carl I. Margolis, M.D. 11125 Rockville Pike, Rockville, MD 20852

Registrar **DHMH 16 Rav 6/95** 

State

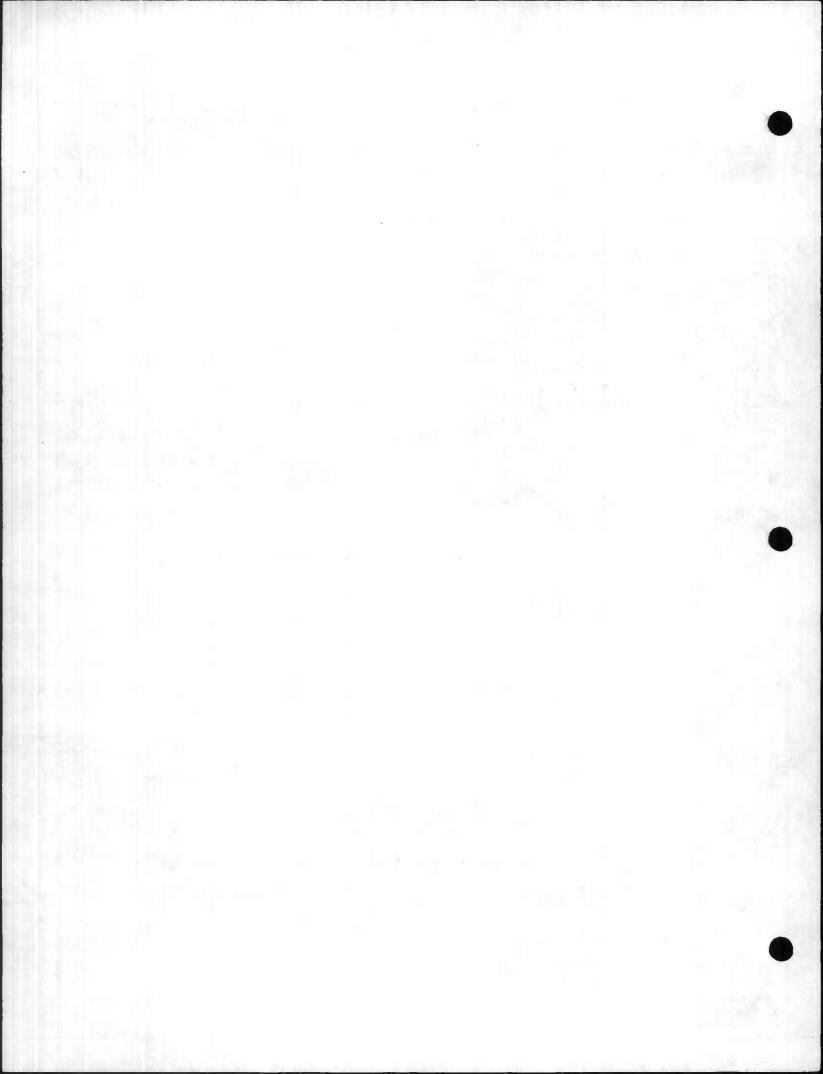
31. Date filed (Month, Day, Year)

DEC 3 1

32. Registrar's Signatura

Deneva

Box 68760 Records, P.O.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month moore Joseph 1040 Dec 1998 QU 24 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Piney Branch Spring Silver 8407 mont romers if Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Deys Hours 11XM 2□ F 579-09-1463 83 Vrs New York Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8407 Piney Branch Road 20901 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Yeer or Dates: 1943-44 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorcad White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) George Moore Gertrude Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Moore 8407 Piney Branch Road, Silver Spring, MD (wife) 20901 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/25/98 Alexandria, Virginia 22. Name end Address of Fecility Francis J. Collins Funeral 21. Signeture of Funeral Servica Licanses 500 University Blvd. West Home, Inc. heuse. Silver Spring , MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Fine) disease or condition resulting in death) 101 Due to (or es e consequenca of) SCVI Sequentially ilst conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequenca of): 23b. Did tobacco use contribute to the ceuse of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 28 No 1 Tes 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

be executed Box 68760. Division of Vital Records, P.O.

sician and burial-transit physician a signed by tha etter peed page 2 certificate has I or Attending Physician: after death. Director: After this certifica illed in by the To the Hospital c within 24 hours at To the Funerel D

**Physician** 

Examiner

**Funeral** 

Director

death with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Meriell Hygiene. Important: If time X7 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner may be notified as

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

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Certification:

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Yes 2□ No 27. Manner of Death
1 Natural
2 Accident 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of cartifier. 29c. License number 29d. Dete signed (Month, Day, Year)

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2101 medical Park Dr

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State Registrar

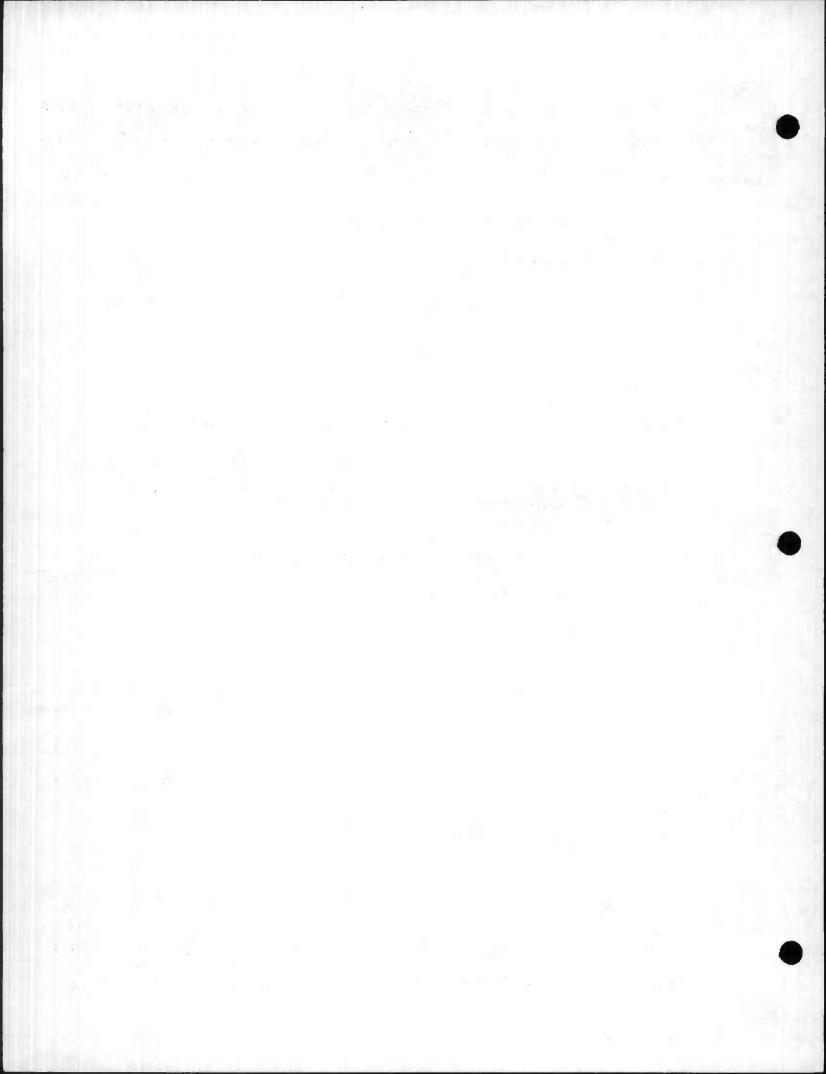
IRA N. BRECHEK, mo DME 31. Dete filed (Month, Day, Year) DEC 28

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

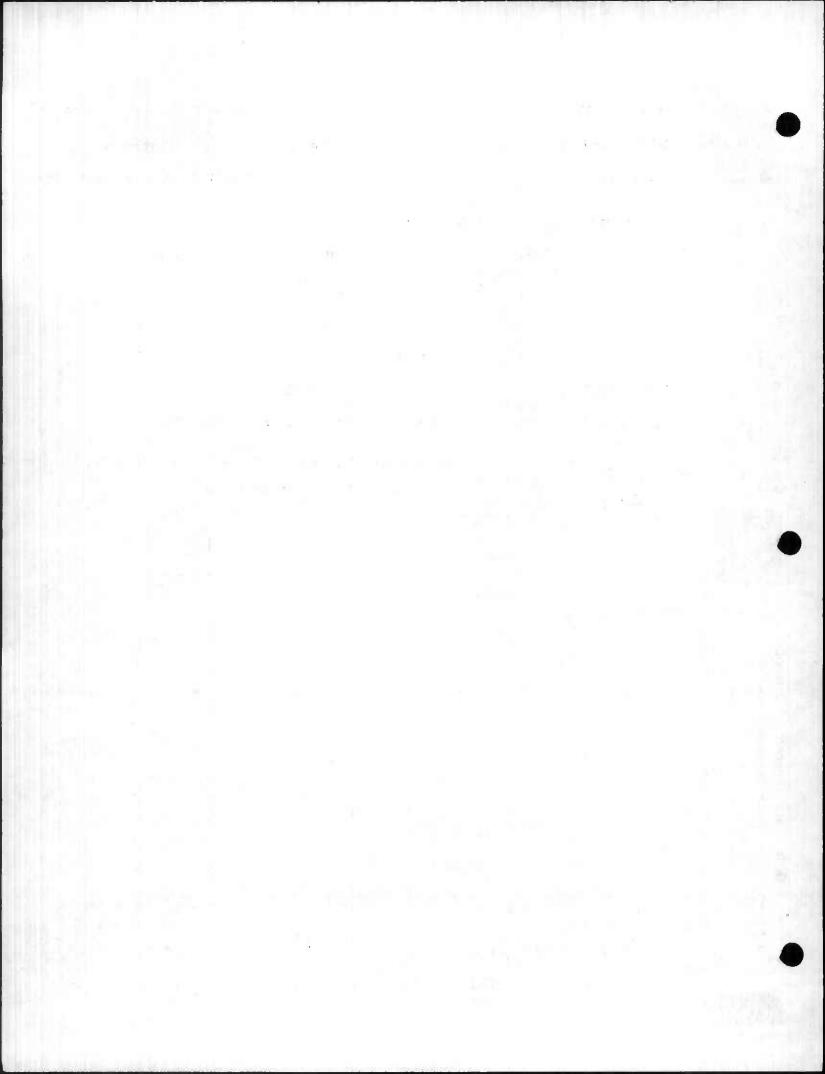
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State of Maryland / Department of Health and Mental Hygiene

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xamine	er	4a. Facility Nama (If not institut	ion, giva stre	eet and numb	er)				4b. City, Town, o	Location of De	ath	4c. County	of Death	
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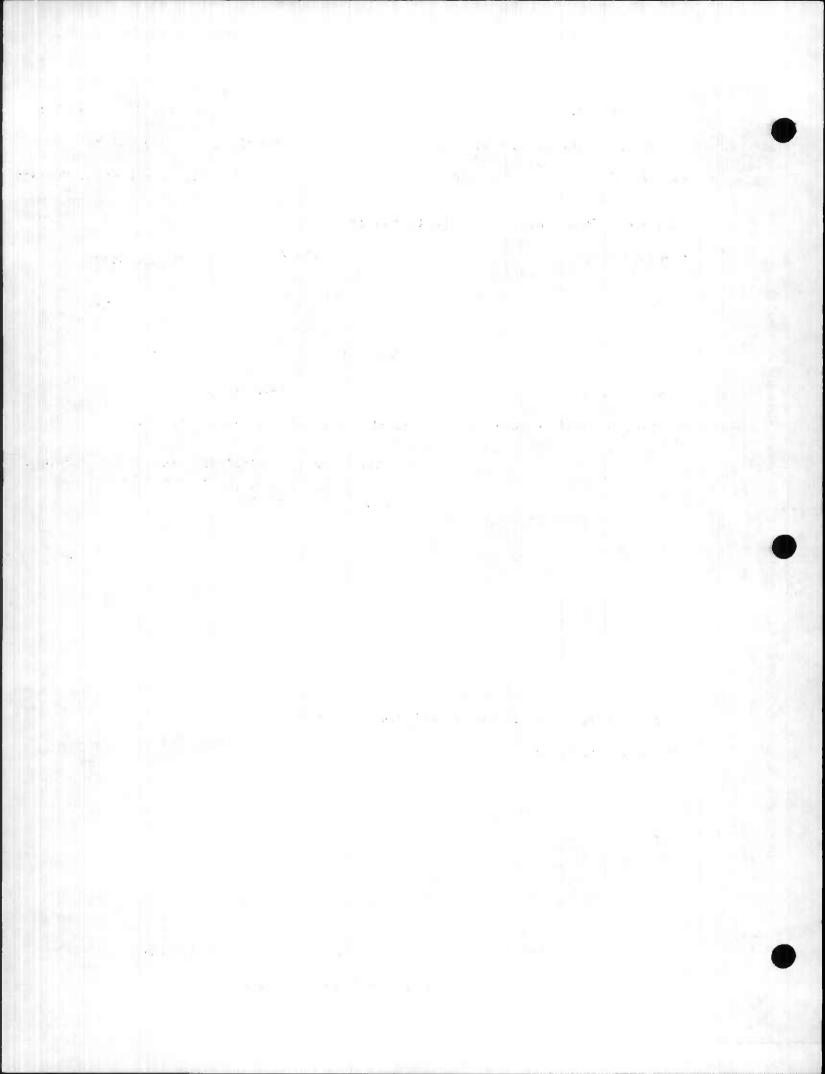


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State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (Fig.	rst, Middle, Last	)		0011			Death	2	2. Date of Dec		Year	3. Tima	a of Deeth
Physician	Samuel Adar	n Moss							D	ecembe	Day 27, 1	998	9:2	25am
/Medical Examiner	4e Fecility Neme (If not		street and number)		-		- 4	b. City, Town			The second second			
<i>ii</i>	Shady Grove	Advent	ist Hosp	ital				Ro	ckvi	11e	Mont	gomer	C.A.	
Funeral	5. Sociel Security Numb	er 6. Se	x 7. Ag		ast birthday)	If Under	1 Yeer Devs	If Under 24		B. Dete of Birt (Month, Da)		<u> </u>	- 16	te or Foreign
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or 26	10e, Street and Number					10f. Zip	Code				10g. Citizen of	What Coun	try?	
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frer death of the free free free free Funeral	11. Maritel Status		12. Was Decedent   Armed Forces?	1	S. 13. W	Vas Decede Yes, speci	ent of H	ispanic Origin In, Mexican, F	igin? (Specify Yes or No- n, Puerto Rican, etc.)			e - America ck, White, e		l <sub>e</sub>
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Men Men To	Hyman Moss									ohen				
9 m m m	19a. Informant's Name/										er, City or Town,		Code)	
Haaith Haaith Ha 27 ther tr	Mildred Dia		(Daughter		1 Puel			t, Gait	ther		MD 208		Chata	
Pages 'sent of H	20a. Method of Dispositi	emetion 3 DF		CE	ametery, crem	atory or of	her plac		1	Date				
t. Partmentant:	4 Donation 5			Met	ropoli	tan (	Crem	atory	12/	28/98	Alexan eral Ho	dria,	Vir	ginia
pemit. Pages 1 and Department of Haalth Important: If item 27 eny injury or other to once.	21. Signeture of Funera	Service Licens	00					er Parl			eral ho	me		
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B	23a. Part1. Enter the di shock, or heart fail	ure. List only of	ne cause on eech li	ne.	i. Do not ente	ir the mode	or dyn	ig, such as ca	rolac or	respiratory ei	rest,		Interval	Between nd Death
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5 a 5	axaminer? 1 ☐ Yes 2M No	1	lospital: 1 🛛 Inpatie		ER/Outpatient			4 LI Nurs	ing Hom	e 5 🗆 Resid	dence 6 □Ott	er (Specify	v)	
frer thunder thunder thunder the same and same a	27. Manner of Death	Pending	28a. Date of Inju (Month, Da)	ry y Year)	28b. Time of injury		Bc. Injur Wor			3d. Describe I	now injury occur	red		
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ours ours filled	29a. Certifier 1 (X Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and								cause(s) and m	anner se et	eted			
To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th complately filled in by the funeral Medical Certification: 7									d at the time,	date and pleca,	and due to	the caus	se(s)	
Withir Comp	29b. Signature and title	of certifier	70/			29c.	. Licens	e number			29d. Date signe	d (Month,	Day, Yea	nr)
1	1 41.	~ et	Luy			1	D424	03		. 1	December	28,	199	8
4	30. Name and address of	of person who co	ompleted cause of d	leath (Item	23a) (Type, F									
	Raj Mathur,	M.D. 1	06 Irving	Stre	eet, Wa	shin	gtor	, DC 2	20010	)				
	31, Date filed (Month, Da			ar's Signat										

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 26, Paul Eugene Maldeis Dec. 1998 2:15am 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6143 Forest Lane Eldersburg Carroll H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug 14, 1954 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 11XM 2□ F Days 44 213-68-2465 Yrs. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6143 Forest Lane 21784 U.S.A. 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Computer Science 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Walter Maldeis Doris Croop

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195)

Sykesville, MD 21784 (410)-795-1400

Data

20c. Location - City or Town, State

Approximate interval Between Onset and Deeth

YEARS

12/29/98 Hampstead, MD

6143 Forest Lane Eldersburg, MD 21784

**Physician** /Medical Examiner

Department of important: If any injury or

**Physician** 

/Medical

Examiner

10a. Stete

MD

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funerel Service Licansee

20a. Method of Disposition

Immediete Cause (Final disease or condition resulting in death)

31. Date filed (Month, Day, Year)

Mrs. Nancy E. Maldeis (wife)

Yau

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

DEC 3 0 1998

RESPIRATORY

1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State

**Funeral** 

Director

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Hygiene.

.. Pages 1 and 2 should be liled w tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, in

Director

Funeral

Completed by

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the Maryland

liled within 72 hours after death

Baltimore, Maryland 21215-0020

burial-transit and the

Attending Physician: The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. certificata this funeral Medical Certification: After To the Hospital or Attend within 24 hours after death To the Funeral Director; filled in by

	RECURRENT	PULMONAR	Y INFECTIONS	& FIBROSIS	YEMS
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaase or Injury that initieted events	. AGAMMA GL	OSULINENT as a consequence of	uA		YEARS
resulting In death) Lest	d.				
Part li. Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given In Pert i.		ntribute to the cause of death
				24a. Was an autopsy performed?	24b. Were sutopsy findings available prior to completion of cause of death?
25. Was casa ratarred to medical			26 Place of De	ath (Check only ona)	1 ☐ Yes 2 ☐ No
exeminer?	Hospitel: 1 ☐ inpatient 2 ☐	ER/Outpatient 3□	Othor		er (Specify)
27. Manner ot Death  1 ☑Naturel 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurr	red
3 Suicide 6 Could not be determined	28e. Placa of Injury - At he building, etc. (Specify	ome, farm, street, fec	ory, office	28f. Location (Streat end Numb City or Town, Stete)	er or Rural Route Number,
29a. Certifler (Check only one)  Certifying Ph. 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and menner steted.	wledge, death occurr tion end/or Investigat	ed at the time, data and plac on, in my opinion, deeth occ	e, and due to the causa(s) and ma urred at the time, date and placa, a	nnar as stated. and due to the ceuse(s)
29b. Signeture end title of certifier  Aug Genstente	the last		29c. License number	29d. Dete signed	d (Month, Dey, Year)
ay Justente	WC, MIL		D20724	Dec.	28, 1998

Sparker

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)

23a. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequenca of):

Dr. Jay Gerstenblith, M.D. St. Agnes Hospital, Baltimore, MD 21229

32. Ragistrar's Signature

Carroll Cremation Serv.

completely

State

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Departm

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Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 3. Time of Death 2. Deta of Death Month **Physician** ELEANORA ROSS MORGAN Dec., 22, 1998 10:40AM /Medical 4b. City, Town, or Location of Daeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner HOSPICE HOUSE EASTON TALBOT Hours Min. 8. Data of Birth (Month, Day, Year) AUG 22, 1904 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Sax 1□ M 2□ F **Funeral** Months Days Yrs. MARYLAND 218-03-0448 94 Director Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits Yas 2 No MARYLAND ST. MICHAELS TALBOT Directo 10f. Zip Coda 10e. Street and Numbar 10g. Citizen of What Country? "natural", or items 23s or odical Exercises must be 21663 112 MILES LANE, UNIT 122 U.S. death Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yeer or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Maritei Stetus Bleck, White, atc Pagas 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If Item 27 Is merked other then "natural", or Iter 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: p 3 ☐ Widowed 4 M Divorced WHITE the Medical Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) SEAMSTRESS GARMENT 11 -0-7 is marked other traumatic event, if 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Be THOMAS J. ROSS SARAH E. HARRISON 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Raiationship (Type, Print) ST. MICHAELS, MD. 21663 ELVA JOAN MORGAN / DAUGHTER 112 MILES LANE, UNIT 122 Item 2. 20b. Piace of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata 20a. Method of Disposition Department of Important: If it any Injury or o 1 Buriel 2 Cremetion 3 Removel from Stata 4 Donetion 5 Other (Specify) 12-28-98 JOHN'S CEMETERY TILGHMAN. MD. 22. Nama and Addrass of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 21. Signature of Funaral Parvice Licensee CFS.P. 200 S. HARRISON ST. EASTON, MD. 21601 23a. Pert1. Inter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset end Deeth **Physician** /Medical immedieta Cause (Final disease or condition resulting in death) (0 m 0S Examiner 12005 Examin physician and s the burial-transit the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Division of Vitai Records, P.O. Box 68760, Physician/Medical 88 for use as 2 signed by the a Pert ii. Other significant conditions contributing to death but not resulting in tha undarlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings evallabla prior to complation of causa of death? 24a. Was en eutopsy Obstructive pulmoney DS. Completed certificate has b irector, page 2 s 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) #OSPICE P 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA shis funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. injury at Work? Certification: Attending 1 Natural 5 Pending s after des. al Director: After 1 Yes 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of injury - At homa, farm, streat, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. Licensa number 29b. Signeture and title of certifiar Dec. 22, 1998 H - 4258730. Nama and addrass of person who complated cause of daath (Itam 23a) (Type, Print)

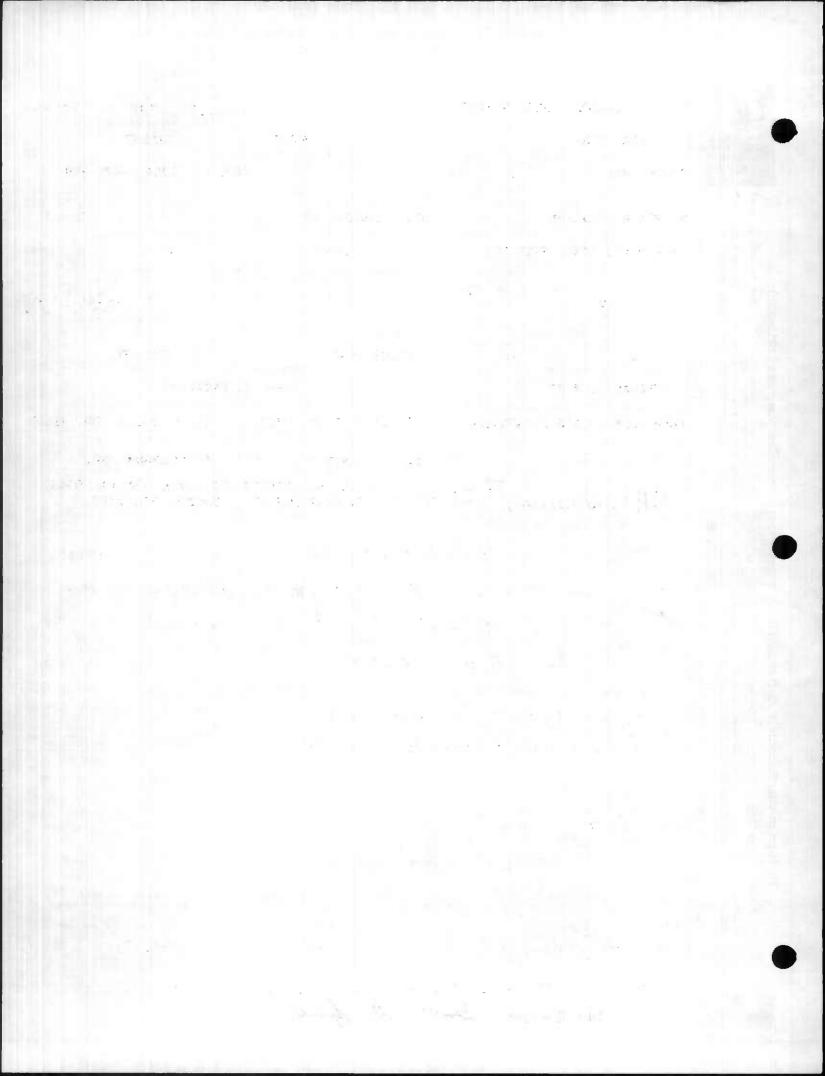
2540 Centreville Rd.: Centreville, Md. 21617

State Registrar Russell Schilling;

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31. Data filad (Month, Day, Year)

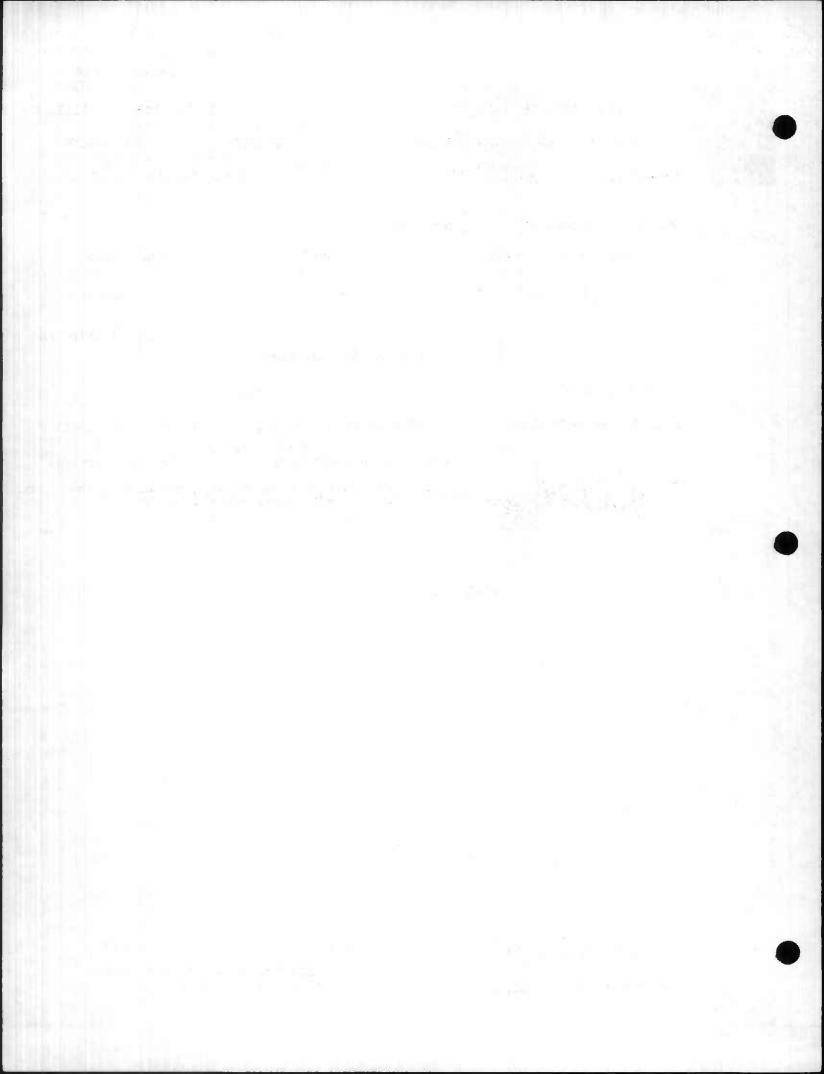
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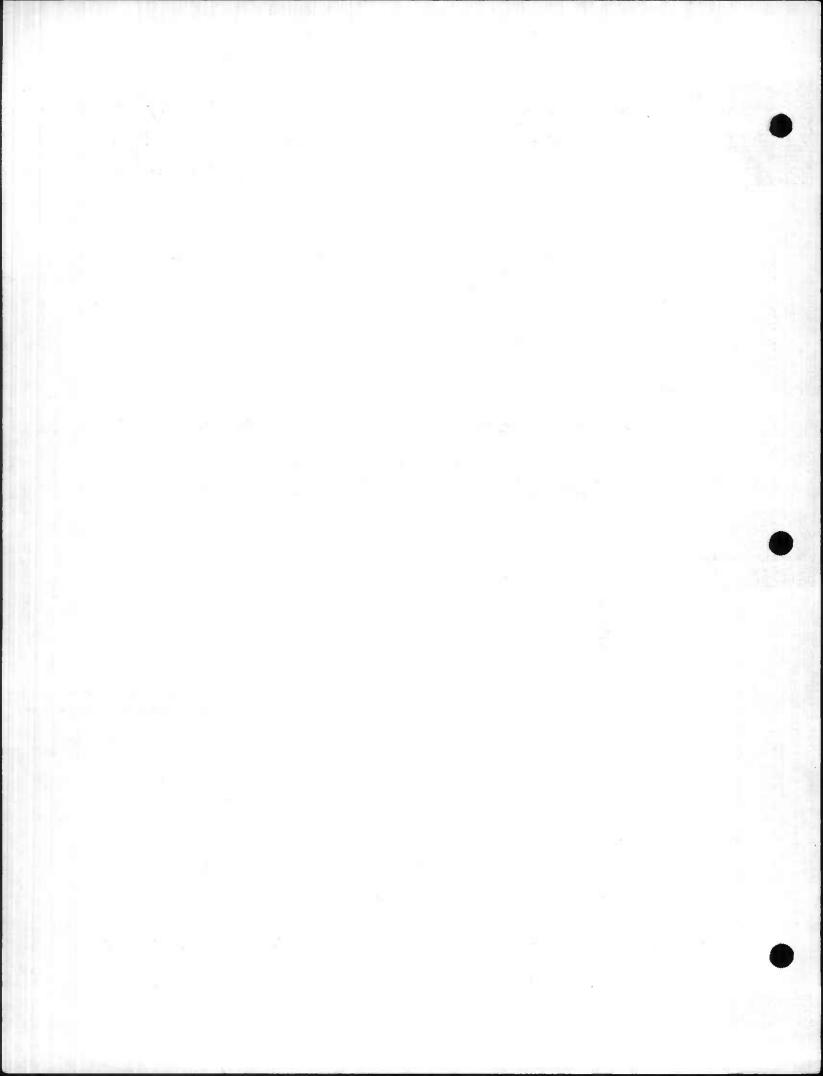
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xamin	er	4a. Facility Name (If not institution	a citie and in the					4			ocation of Deatl	4c. Count	y of Death	
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nerai		5. Social Security Number	6. Sax 1 ☐ M		Age (In yrs. 80	last birthday) Yrs.	Months Months	Days	if Under : Hours	Min.	8. Data of Bir (Month, Da	th y, Year)		lace (State or Foreign try)
ector		559-14-7641 Usuei Rasidence of Decedant			00	113.					January	24, 1918	Mary	land
12		10a. Stata 10b. Count	у		10c. Cit	y, Town or Le	ocation						10	0d. Inside City Limits
pal	jo	Maryland Mon	tgomer	.,	Po	thesda								1 ☐ Yas 2 1 No
Examiner must be notified at	Director	10e. Street end Number	LEGOMET	у	De	Luesda	10f. Zip	Code				10g. Citizen of	What Count	trv?
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	Be	17. Fathar's Nama (First, Middle	, Last)						18. Mothe	r's Name	e (First, Middla,	Maidan Suma	ma)	
	0	Garnett Y.	Clark						He1e	n Hu	int			
		19a. Informant's Name/Relation	ship (Type, F	Print)		19b. Maili	ng Addrass	(Street	and Numbe	r or Run	al Routa Numb	er, City or Town	, Stata, Zip	Code)
		John H. Newton	/Husba	ind		9510	Kent	ston	e Dri	ve.	Bethese	la, Mar	vland	20817
		20a. Method of Disposition	- (7)-		20b. F	Place of Disponentary, cra	sition (Nar	na of other plac	e)Decem	hor	29, 1998	20c. Location		
once.		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (		al from St		ntgome						Bethes	da. Ma	aryland
		2. Signature of Funaral Sarylo	Licens			2	2. Nama an	d Addras	s of Facility	v				
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	hys	Tarin. Other significant contra	One contribu	mig to deat	n but not res	uiting in that u	indanying c	ausa give	ari iri r-eari i.					nably 4 🔀 Unknow
	by P													- AN OHALOW
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		27. Manner of Death  1 Natural 5 Pandi 2 Accidant invest		a. Date of		28b. Tima o Injury		8c. Injury Work				how Injury occu	1-6	
	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Placa of injury - At homa, ferm, straat, factory, office building, atc. (Specify)								28f. Location ( City or To		ber or Rural	Routa Number,	
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						. 23a) (T <b>y</b> pe,	r tirit/					MEDICAL	CENTE	ZR .
0	9	SHARON REED, 31. Data filed (Month, Day, Year	LT, M		NR istrar's Signe	tura 🌶	-			SDA	MD_2088	39-5600		
State	-		1998			//a		aks						

DHMH 16 Rav 6/95



	1. Decedant's Nama (First, Middla, Last)		Cer	tificate of	Death	2. Data of De	Reg. No.		2 Time of State
ın	1. Decedant's Nama (Filst, Middia, Last)					Month	Day	Year	3. Tima of Death
al er	Katherine Mary Nash 4a. Facility Nama (If not institution, give street)	and number)			4b. City, Town, or L	12 ocation of Death	1 6	98	8:40 PM
er	CAROLINE NURSING HOM				DENTON		131	LINE	
	5, Spclai Security Number 6. Sax	7. Aga (In yrs	. last birthday)	If Undar 1 Yaar	If Undar 24 Hrs.	8. Data of Birt (Month, Da			laca (Stata or Foraig
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Director	10e. Street and Number	De.	iteon	10f. Zip Code			10g. Citizan of	What Coun	try?
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Funeral	11. Marital Status 12. Wa	as Decedent Evar in	U,S. 13. V	1	Hispanic Origin? (Sp pan, Mexican, Puarto	ecify Yas or No		ce - Americ	
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sted	15. Decedent's Education (Specify only highast grada comp	nleted)	16a. Deced	ant's Usual Occup	pation during most of worked)	ina	16b. Kind of B	usinasa/ind	lustry
Completed		ellega (1-4or 5+)	lifa. E	O NOT use retire	ed)	ang .			
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Be	17. Fathar's Nama (First, Middla, Last)  Andrew Reese				18. Mothar's Nam	-		na)	
2	19a. Informant's Name/Relationship (Type, Pri	intl	10h Mellin	a Addrage (Street	t and Number or Rur			Ctate 7in	Code
		ughter			or Road,			629	Code)
	20a. Method of Disposition	20b.		sition (Nama of latory or other pla		Data	20c. Location		wn, Stata
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	ai iioiii State		Memorial	DE	c. 19,	1998 Easton	, MD	
	21. Signature of Funarat Sarvice Licenses	1	22.	Nama and Addre	ass of Facility				
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ou	1 ⊠Natural 5 □ Panding	. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo	ryat irk? ]Yas 2 □ No	28d. Dascribe i	now Injury occur	rred	
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dical Certif	29a. Certifiar (Check only one)  1 ★ Certifying Physician: 2 ★ Medical Examiner: Or an	d mannar stated.							
Medical Certification:	(Check only 2 Medical Examiner: Or	d mannar stated.		29c. Licens	sa number		29d. Data şigne	ed (Month, I	Day, Year)
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Medical Certif	(Check only one) 2 Medical Examiner: Or an	d mannar stated.		D4-				1	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** SAUL OLIN 9:20AM 12 26 /Medical 4a Facility Neme (tf not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Montgomery Potomac Arden Courts Assisted Living Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) Russia 8. Dete of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 M M 2□ F 153 26 4227 100 Director 09-18-1898 Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits r than "natural", or hema 23a or 28a-f show the Wedical Examiner must be notified at Potomac 1 ☐ Yes 2 ☐ No Director MD Montgomery 10a Street and Number 10f. Zio Code 10g. Citizen of What Country? 20854 11902 Milbern Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 72 hours after 1 Yes 2 No 1 Never Married 2 Merrled 1 ☐ Yes No Specify: 3☐Widowed 4 ☐ Divorced Specify: White p Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ified within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien important: if them 27 is marked other the any injury or other treumatic aware many injury or other treumatic aware many injury or other tre Retail Goods 10 Self Employed 17. Fathar's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unkown Israel Olin 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 11902 Milbern Dr, Potomac, MD Erwin Olin Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State PARAMUS, 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal Irom Stete 2-29-1998 4 ☐ Donation 5 ☐ Other (Specify) New Jersey Cedar Park Cemetery 21. Signature of Funeral Servica Dicensee 22. Name end Address of Fecility Danzarsky-Goldberg Memorial Chapel, 20852 the disease, or complications that caused the death ant lailure. List only one cause on each line. 23a. Part1. Enter Approximate Interval Between Onset and Deeth Qo not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 4 days Examiner Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): ettending Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? detached tha signed by t 1 Yaa 2 PNo 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy peen page 2 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Diving Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturai 5 Panding death. 1 ☐ Yes 2 ☐ No investigation 2 Accident sfler death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, tectory, office building, etc. (Specify) 4 Homicide c To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. edical 29a. Certifier

31. Date filed (Month, Day, Year)
DEC 29 State Registrar

(Check only one)

Martin S

29b. Signature and title of certifier

Kanovsky

1998

MO 32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

5530 Wisconson Ave +730 Chery chase MD 20815

29c. License number

29d. Date signed (Month, Day, Year)

12/27/9

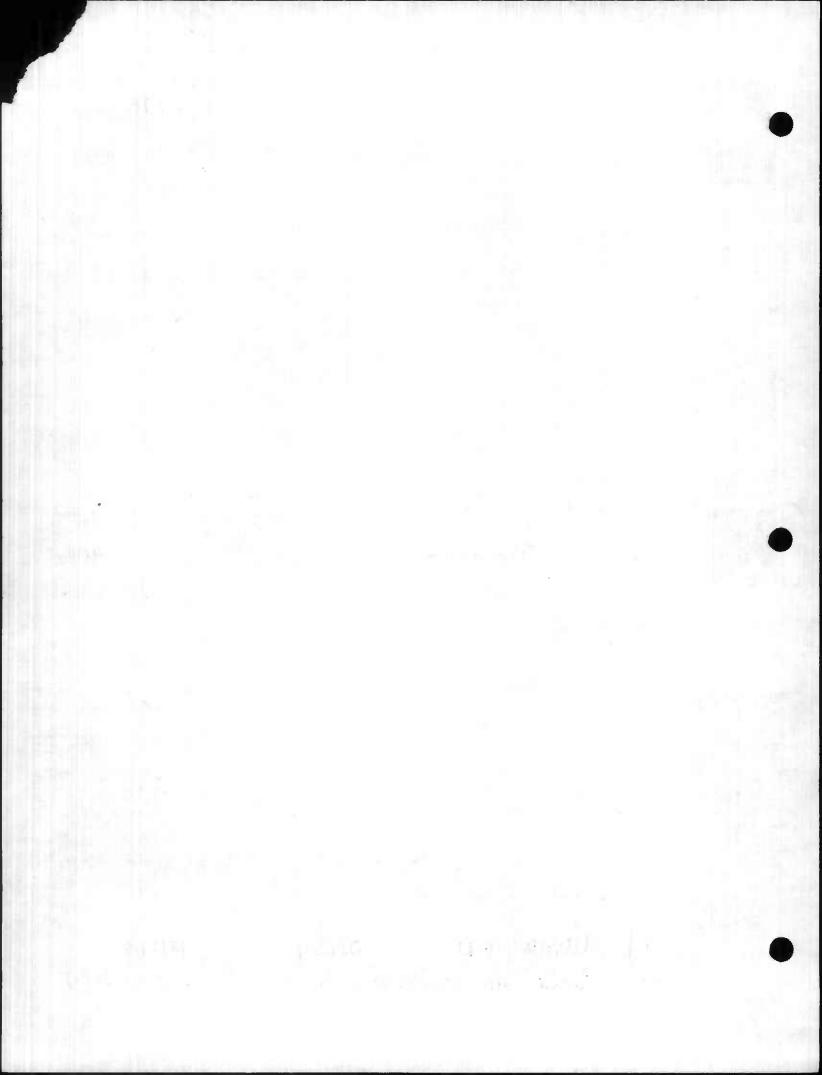
Baltimore, Maryland 21215-0020

Box 68760

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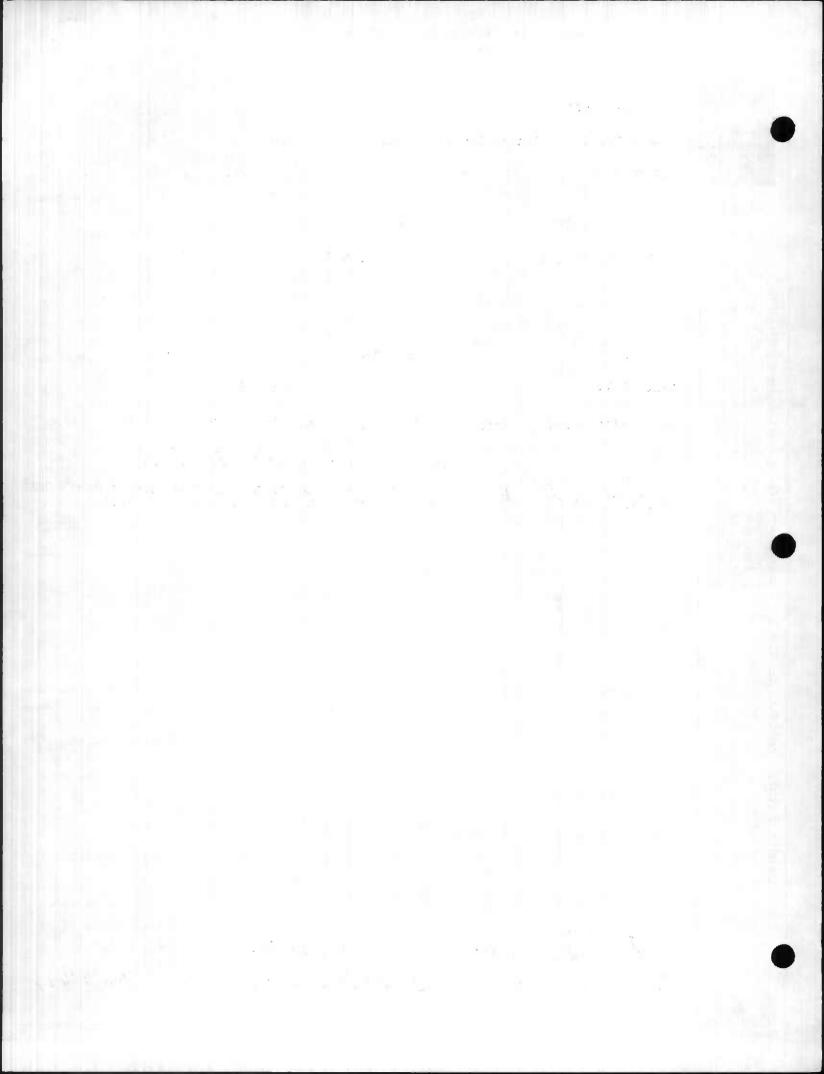
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				Ce	rtificate c	of Death			g. No.		
Physician	Decedent's Nama (First, Midd							Data of Deat Month	Day	Yesr	3. Time of Death
/Medical	Charlotte Ott					4h City Tay		ec.	T	1998	8:20 PM
Examiner	4a Facility Name (If not institution Shore Nursing			n Cont	0.10	Dent.	wn, or Locatio	II OI Death	4c. County		
Everage L	5. Social Sacurity Number	6. Sex	7. Age (In yrs.		7 44 5 6 4 5 6		24 Hrs. R C	ate of Birth	1		ace (State or Foreign
Funeral Director	155-36-9939	1□M 2∏F	96	Yrs.	Months Da	ys Hours	Min. (	Month, Day,	1902	Gern	ry)
	Usual Residence of Decedent										
T E	10a. Stata 10b. County		10c. Cit	ly, Town or Lo	ocation					10	od. tnside City Limits  1 ☐ Yes 2 ☐ No
octo	NJ Berg	en	Dem	arest	Tank miles						
Dir.	10e. Street and Number				10f. Zip Cod				Og. Citizen of V	vnat Count	ryr
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumstic event, the Medical Examiner must be notified as pace.  To Be Completed by Funeral Director	41 Blanche Ave		cedent Ever in U	S. 13.	0762 Was Decedent		oin? (Specify		J.S.A.	e - America	in Indian,
F. F.	1 Navar Married 2 Mar	Armed	Forcas?		If Yes, specify C	uban, Maxican	, Puarto Rica	n, etc.)		k, White, e	
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ovent, tre Medical Be Completed	15. Deceder (Specify only highe	it's Education	d)		dent's Usual Oc		of working		16b. Kind of Bu	siness/Ind	ustry
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Co	12	Local		Hom	emaker	10 Metho	do Nama (Eir	nt Middle A	Self Maiden Sumam	al.	
, m	17. Father's Name (First, Middle,	Lasi)					a Wolf	St, MIGGIE, A	MEIDEN SUINAIN	9)	
To	Georg Wilm  19a. Informant's Name/Relations	chin /Time Print)		19b Maili	ing Address (Str			ute Number	City or Town	Stata 7in	Code)
treu	Erika Edith Ro		aughter		Congres						21666
othe	20a. Method of Disposition	OI D	20b. F	Piaca of Disp	osition (Nama o		D	ate :	20c. Location -		
yor	1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (5		n State		matory or other ashingto		Dec.	18, 19	998 Paramus	NI	
I d	21. Signature uneral Serv		1.	-2	2. Name and Ad	dress of Facilit	у				
any ir	1 maple	Wich	101111								lome, P.A.
	23a. Part 1. Enter the dishase, o shock, or heart fail ire. Lis	con all cations tha	caused the deal	h Do not en	06 Sham ter the mode of	rock Ro dying, such as	cardiac or res	ester	, MD 2	1619	Approximata
ician	shock, or heart faill re. List	only one cause or	each line.							i	Onset and Death
icai	tmmediate Cause (Final disease or condition				Drown	· 1 / 10-				1	(1. h-
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- Per		<b>-</b> b			No.~	Ane	a				
dical Examiner	Sequentially list conditions,		Due to (d	or as a conse	quence of):						
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s the burial-transit	that Initiated events rasulting in death) Last		Due to (c	or as a conse	quenca of):						
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d be detached for use es	^	,	death but not res	mini bin me r	indenying cause	given in Fart I.		1 🗆 Y	- CANAL	3 □ Prob	
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N Q	25. Was case referred to medica	1		nt 3 DOA	Other:	rsing Home	5 Reside	nca 6 🗆 Oth	er (Specif)	)	
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Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ressie E. Paige December 25, 1998 6:45 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park
If Under 24 Hrs.
Hours Min.
8. Dete o Park Montgomery

8. Date of Birth (Month, Day, Year) 1922

9. Birthpleca (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 20 F Deys 578-26-6539 Virginia Director 76 February 20, Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r then "netural", or items 23s or 28s-f shore the Medical Examiner must be notified at MD Prince George Hyattsville M Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8402 26th Place 20783 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Merital Stetus Black, White, etc. 1 ☐ Yes 2 ◯XNo 1 ☐ Never Married 2 X Merried Baitimore, Maryland 21215-0020 **Black** 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flem 27 is marked other than any injury or other traumests. Elementary/Secondery (0-12) College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Rev. George W. Berkley Euphemia Coles 19a. Intormant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Paige - Husband 8402 26th Place, Hyattsville, MD 20783 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removei from Stete Cedar Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/2/99 Faber, VA 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. 21. Signature of Funerei Service Licensee ) Lines 600 Kennedy Street, N.W., Wash., DC 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, ehock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner leans requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or as e consequence of): physician s the buriel Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of) USB BS attending signed by the sid be detached if Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably by s peen s 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 NO certificate Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Menher of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Pending investigation Netural s after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, State) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 4 ☐ Homicide edicai 29e. Certifier 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Cer

Sajeer Anand

31. Date tiled (Month, Day, Year)
DEC 3 0

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

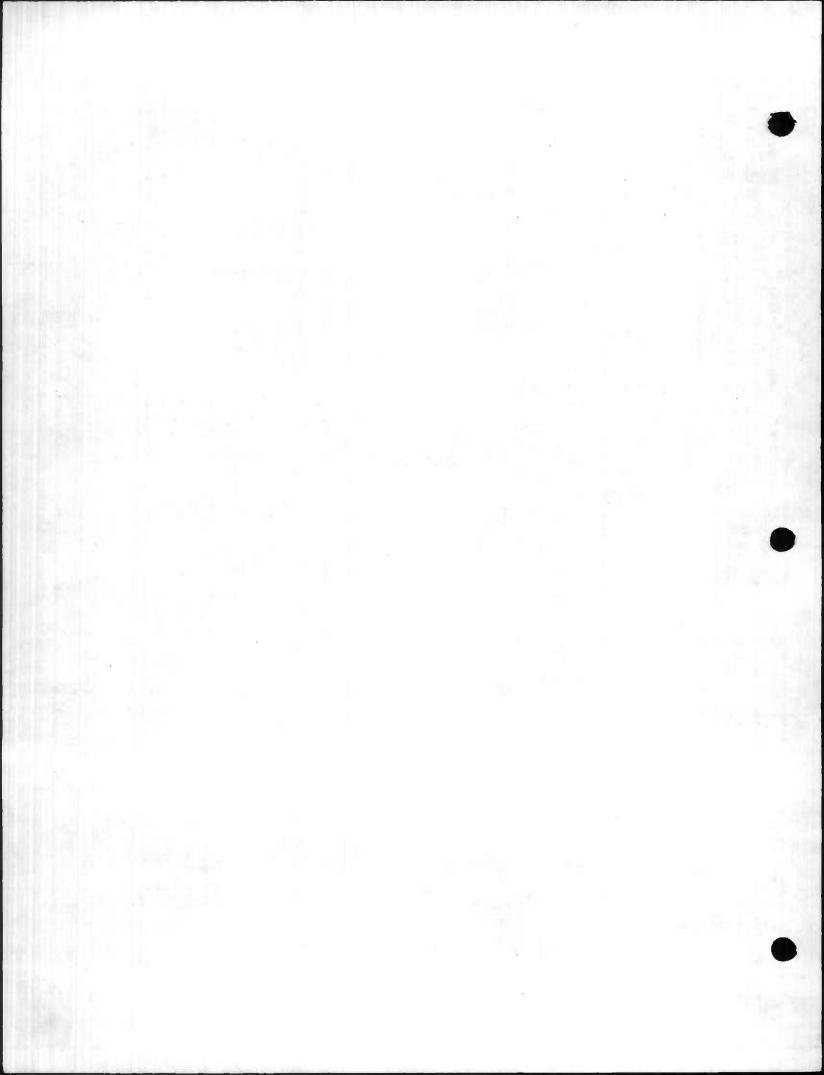
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32. Registrer's Signature

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Hanver

Parkway Greenbelt, Maryland 20770



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	State of Mar	yland / Depa	rtment of H	lealth and Me	ntal Hygiene

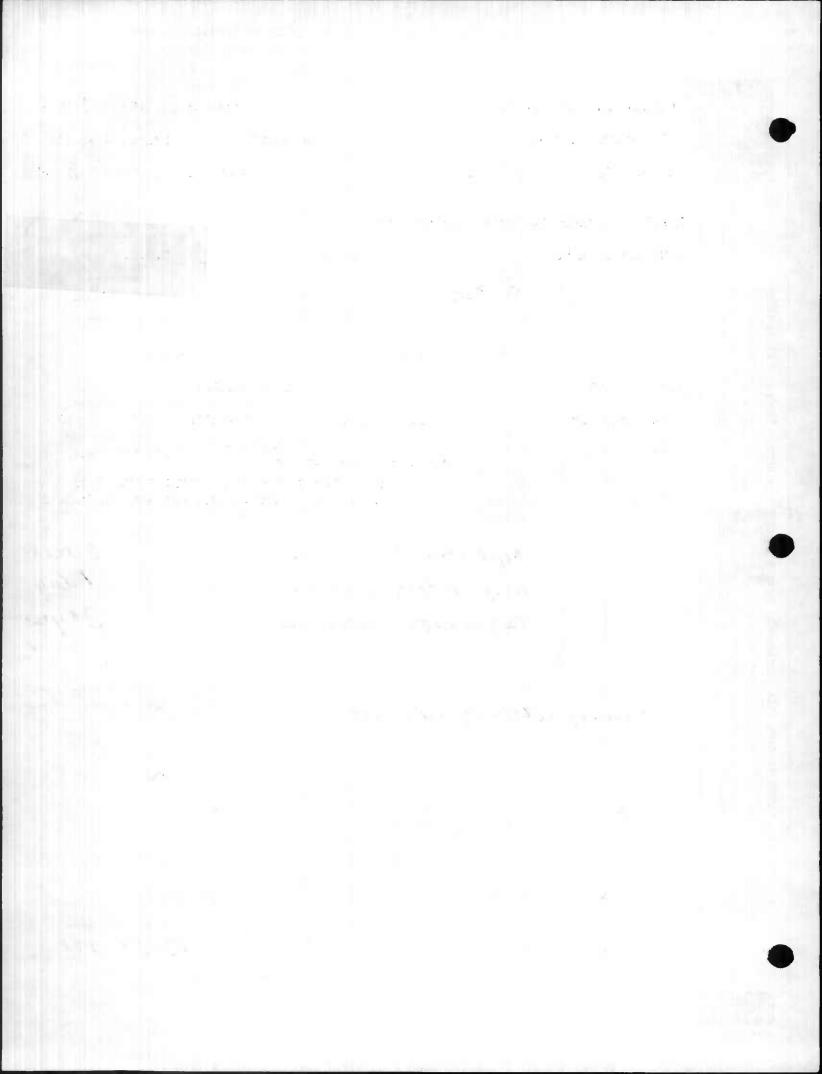
Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Yeer Month **Physician** WILLIAM R. PERL, PH.D. 24, 1998 9:49 AM December /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3901 Harrison Road Beltsville Prince George's If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthdey) **Funeral** Deya Hours Months 12€ M 2□ F 262-42-4153 92 Sept. 21, 1906 Czechoslovakia Director Usual Rasidence of Decedant the Maryland 10a Stata 10d. insida City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Ves 2 No Director Maryland Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 3901 Harrison Road 20705 U.S.A. Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yas or No-It Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian Bieck, White, atc. 12. Was Dacedent Ever In U.S. Armed Forces? 11. Maritel Stetus 72 hours efter 1 Yas 2 No If Yes, Giva WWII Yeer or Detes: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Health and Mental Hygiene important: If them 27 is marked other than 'n any injury or other traumate Elamantary/Secondary (0-12) College (1-4or 5+) 5+ Psychologist Medical 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Surnama) Be 2 Rudolph Perl Camilla Fischer 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) Lore Perl, Wife 3901 Harrison Road, Beltsville, Maryland 20705 20b. Place of Disposition (Nama of camatary, cramatory or other place) 12/27/11998 20c. Location - City or Town, Stete 20a. Mathod of Disposition XXBuriai 2 Cremation 3 Ramoval from State Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 21. Signature vera Se ice Licensee 22. Name and Addrass of Fecility
STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Willed 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 23a. Fart 5 m. Ta disaasa, or complications thei caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shoot or heart tailure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** a. Aspiration Presumon

Dua to (or as a consequence of):

b. Respiratory Laiku

Due to (or as a consequence ot): /Medical Immedieta Causa (Finel 3 Week disease or condition resulting in death) **Examiner** Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Dissess or Injury that initiated avants resulting In death) Lest certificate be execu Division of Vital Records, P.O. Box 68760. eliteate Physician/Medical Dua to (or as a consequence of 89 950 Pop the Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco ues contribute to the cause of deeth? detached signed by t 1 Yes 2 No 3 Probably 4 Unknown atthery olivease þ 24b. Wera autopsy tindings available prior to completion of ceusa of death? 24a. Was an autopsy Completed page 2 1 Yas 20No 1 ☐ Yes 2 ☐ No 25. Was cesa rafarrad to medicel axaminar? or Attanding Physician: funeral director, Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Mennar ot Death 28b. Time of 28c. tnjury et Work? 28d. Dascribe how Injury occurred Certification: 5 Pending Invastigation 1 Natural s after death. 1 Tes 2 No 2 Accidant 6 Could not be datarminad 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 24 hours a Funeral D 15 Certifying Phyeictan: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and mennar as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, dete and place, and due to the causa(s) and mannar stated. 29a. Cartifiar edical (Check only one) within 2 To the 29c. Licansa number 29d. Dete sloned (Month, Dev. Year) 29b. Signature and title of certifier December Ecogemann 0004483 D 30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Till Bergemann, M.D., 115 Centerway Road, Greenbelt, Maryland 20770 31. Dete filed (Month, Dey, Year)
DEC 3 0 32. Redistrar's Signatura State

DHMH 16 Rev 6/95



**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner next be notified at

Directo

Funeral

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Completed

Be

the Maryland

death with

should be filed within 72 hours after ond Mental Hygiene.

marked other than "naturel", or ite

permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 Is marked othe eny Injury or other treumatic event pace.

Baltimore, Maryland 21215-0020

Examiner physicien end s the burial-transit Physician/Medical d for use es t ed by the deteched signed t þ Completed peen has e 2 eged certificate director, Be 2 this funerel Certification: After death. after death Director: / d in by the f

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician:

in 24 hour. the Funerel Directory

To the To To the I

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29a. Certifier

examiner? 1 Yes 2 No 27. Manylar of Death 1 Natural 2 Accidant

25. Was case referred to medical

5 Panding Invastigation 3 Sulcida 6 Could not be 4 Homicide

28a. Data of injury (Month, Day Year) Injury

end manner stated.

28b. Tima of 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signatura and titla of certifiar

29c. Licansa number

29d. Data signed (Month, Day, Year)

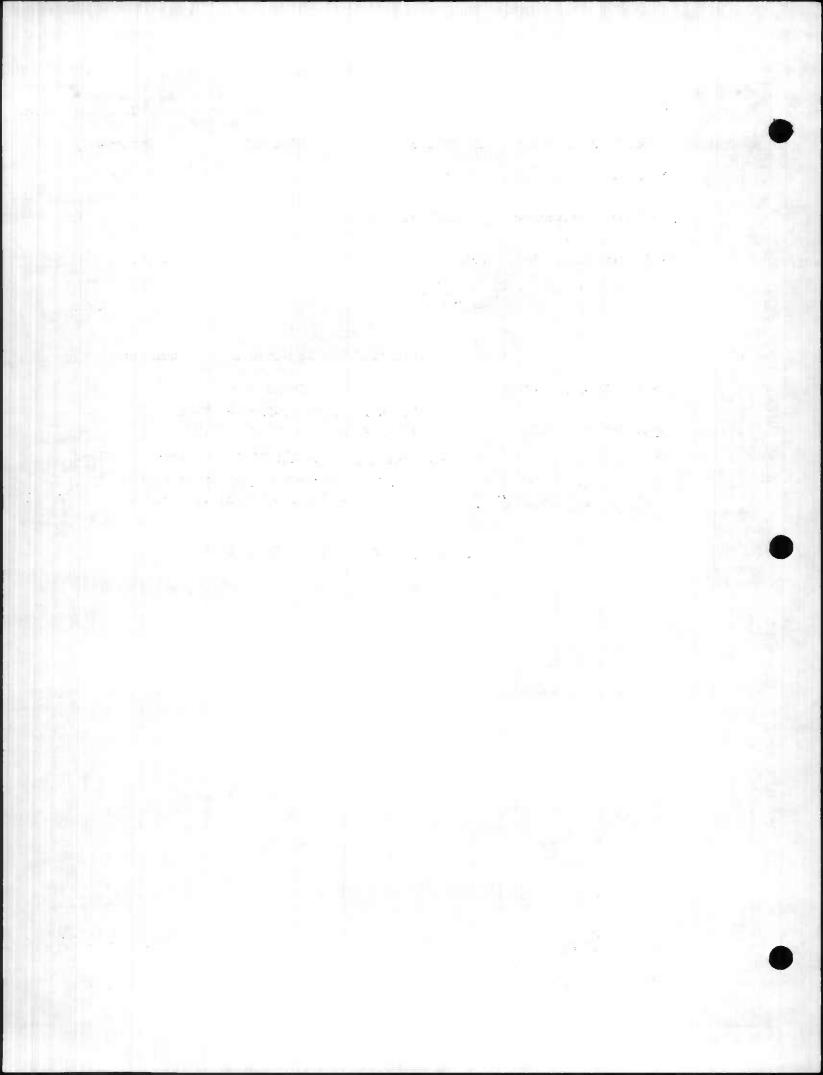
and addrass of person who complated cause of death (Itam 23a) (Type, Print) 6121 MONTROSE M.D.

31. Data filed (Month,

32. Registrar's Signature

Rock VILLE, MO 2082

State Registrar



### Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

**Physician** /Medical Examiner

**Funeral** Director

with the Maryland

r 28a-f show Directo "naturel", or items 23s or Funeral by Completed Be

d 2 should be filed within 72 hours after death to thand Mental Hygiene.
7 la marked other than "naturel", or frems 23st traumetic avent, the Medical Examine must Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe eny Injury or other traumatic avent, pages.

**Physician** /Medical Examiner

as usa ò funeral

Box 68760. signed by the a d be detached f 0 that Records, The law requires should certificata has b lirector, page 2 s Division of Vital Physician: this Attanding death. Director: A To the Hospital or A within 24 hours after To the Funeral Directompletally filled in by after

physician and the burial-transit death certificata be axecuted Physician/Medical à Completed Be 2 Certification: Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Lillian H. Phillips December 26, 1998 11:18 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 1.0 3330 North Leisure World Blvd. #210 Montgomery 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) 1□M 21 F 212-03-6887 83 Yrs July 22, 1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 ☐ Yes 2 ☒ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 N. Leisure World Blvd #210 20906 United States Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 X Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Bank 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Ludwell Lee Goldie Caton 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)? 3330 N.Leisure World Blvd. #210, Silver Spring, MD Chester C. Phillips/Husband 20b. Piece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Mt. Zion Cemetery Dec. 30, 1998 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or feart feiture. List only one ceuse on each line. Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Ischemic Cardiomyopathy Years Due to (or es e consequenca of): Examiner Coronary Atherosclerosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings avellable prior to 24a. Was an autopsy completion of cause of deeth?

1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 X Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner stated.

29c. License number

D05568

29d. Dete signed (Month, Day, Year)

December 28, 1998

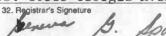
30. Neme and address of person who completed cause of deeth Item 23e) (Type, Print)

Itscoitz, M.D. 10313 Georgia Avenue, Silver Spring, Maryland Samuel B. 31. Dete tiled (Month, Dey, Year)

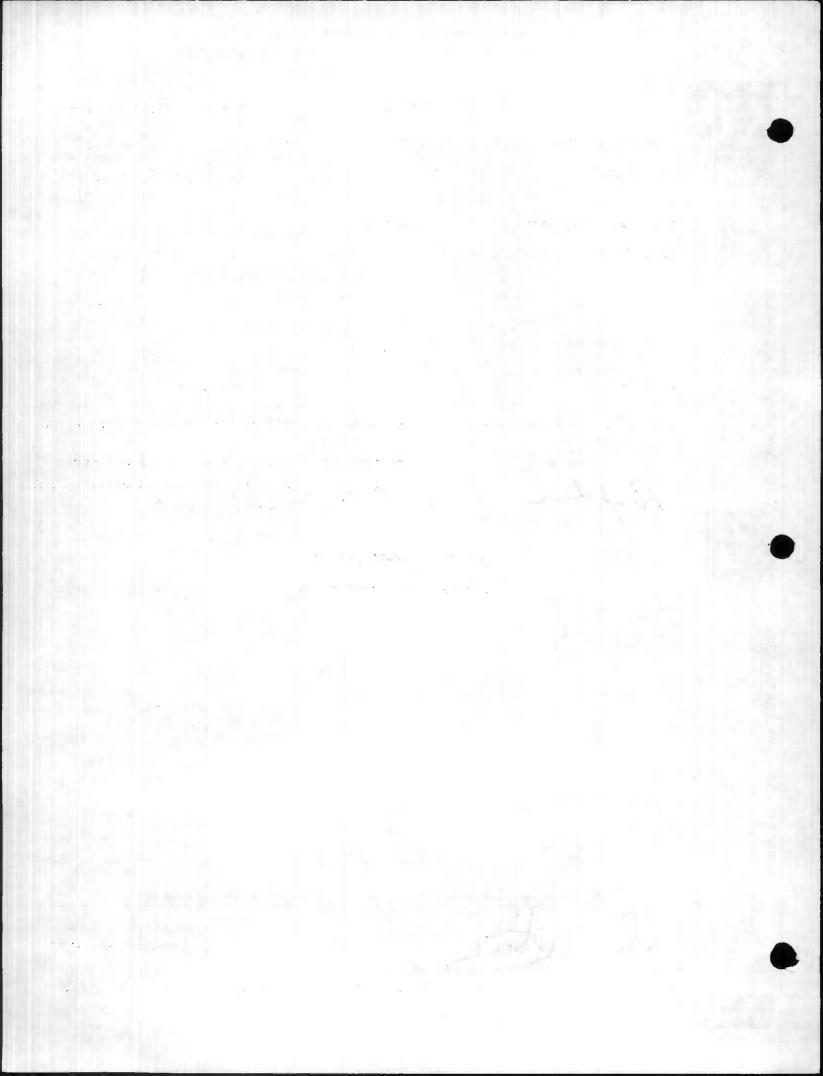
Registrar

29b. Signalu

DEC 30



**DHMH 16 Rev 6/95** 

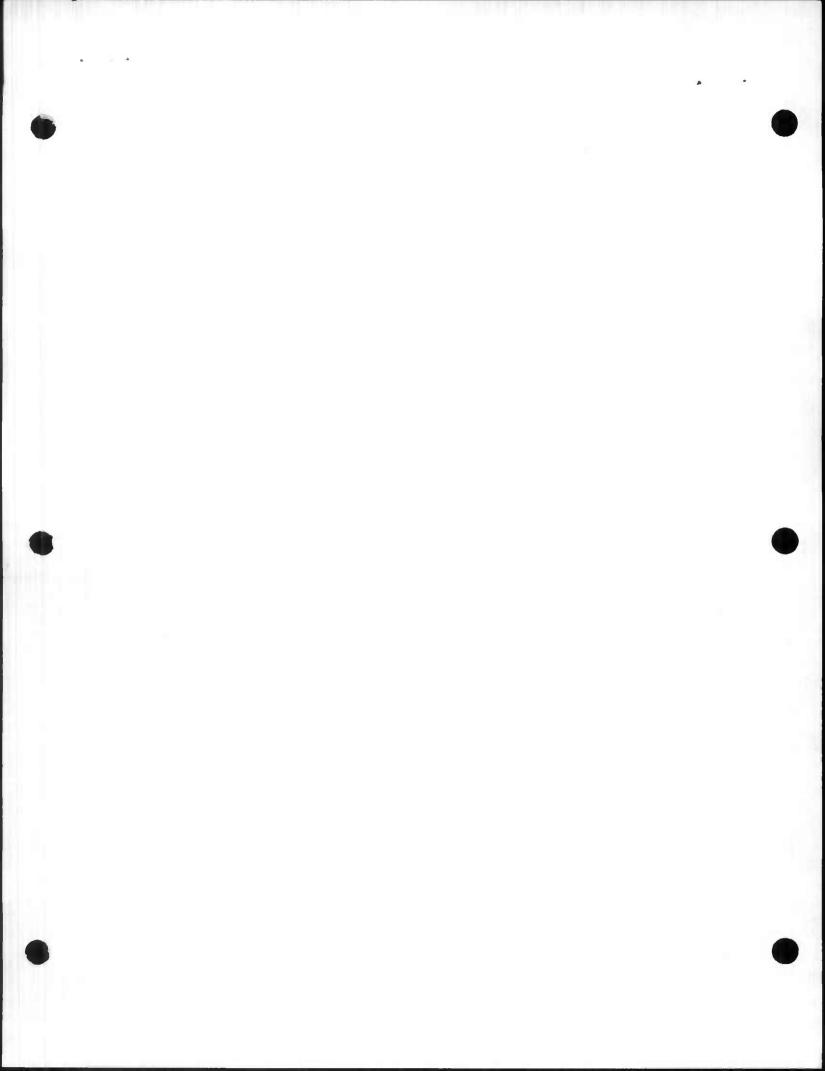


CERTIFICATE # 98-41354

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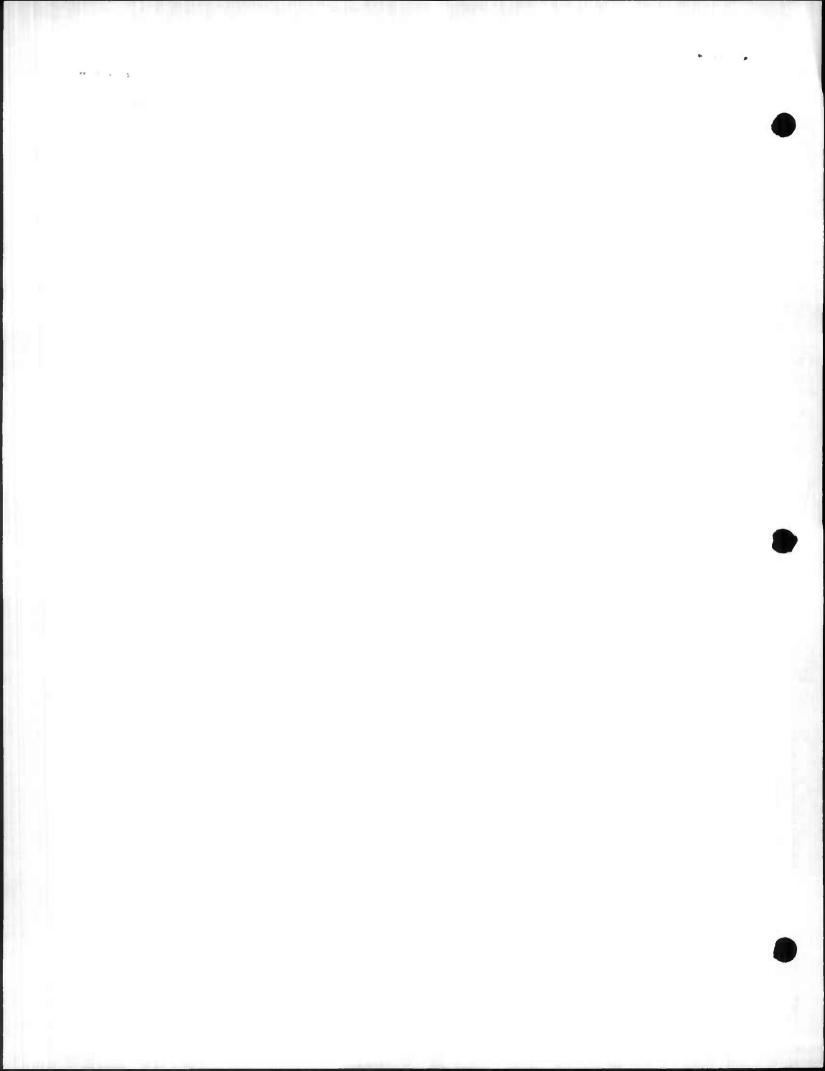
CERTIFICATE M

1998 Cert. For a 1999 Death



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29a. Certifying Physician. To the best of my troubledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.  29b. Schelure and title of certifier  29c. License number  O. C. M. E  29d. Date signed (Month, Day, Year)  JAN. 3, 1999  30. Name and address of person who completed cause of death (from 23e) (Type, Print)  A Lybration  A. Data W. 111 Penn Street, Baltimore, Maryland 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sequentially list of if any, making in death)  Sequentially list of if any, making list of if any, making lot of use (Disease of that influsted event resulting in death)  Part II. Other align  25. Was case referenced in the influsted event resulting in death)  27. Manner of Dae 1 Natural 2 Accident 3 Suicide	on conditions, more distributions of the conditions of the conditions of the condition of t	b.  c.  d.  Hospital: 1   28a. Date (Mon. Found)   1-2'-10' (Mon. Found)   1-2	Due to (c  Due to (c  Due to (c  leath but not rea  Inpatient 2   of Injury  th, Day Year)	or as a consequence or as	COMPLICAT  uence of):  uence of):  deriving cause g  A 28c. Inju M 1 1	26. Place ther: 4 Ni	PHENHYD	23b. Did 1 24a. Was perfi  (Check only  MX Res d. Describe  UNKNOWN	INTRX I CA	3 P	onest and Des
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15. Decedent's (Specify only highest of	Education grade completed)	16a	. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of worl	king	16b. Kind of B	usiness/Ind	ustry
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7. Father's Name (First, Middle, La.	st)			18. Mother's Nerr				
JOSEPH SLATER	2 WILSON			NELLIE	VIOLE	A SAM	PSON.	)
19a. Informant's Name/Relationship		198	. Meiling Address (Street		0			Code)
ARS. MARY ELLA GI	RAVES. SISTI		63 SPELMI	an Ro.		ORE M		1225
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place o cemete	of Disposition (Name of ery, crematory or other pl	lace)	Date	20c. Location		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death 3:50pm Vasi POCTOR ORATIO 98 11 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Nama (If not institution, giva street and number) Baltimore Baltimore MAMIAND MIKRSIT If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, 3/16 Birthplaca (State or Foraign Country) If Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Security Number Months 1 M 2 F Deys 79 Yrs. 217-14-3017 Maryland Usual Rasidence of Dacedant 10c. City, Town or Location 10d fostde City Limits 10b. County 1 Yas 2 □ No Maryland Queen Anne's Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 104 Mimosa Lane 21620 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Year or Detes: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian 11. Meritel Status Black, Whita, atc. 1 Nevar Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3X Widowad 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16h Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Elamentary/Secondary (0-12) Collega (1-4or 5+) Grant Officer Education 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Horatio R. Proctor, Sr. Mary Dryden Worthington 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) James R. Proctor/Son 104 Mimosa Lane, Chestertown, MD 21620 20b. Plece of Disposition (Neme of cematary, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriat 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 12/17/98 Chestertown, MD Pauls Cemetery 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest. Interval Batween Onset and Death Immediate Cause (Finel disease or condition rasulting in death) 8 hours Hypotension Due to (or es e consequence of): 24 hours Ci th P 25 27

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

attending physician end for use as the burial-transit signed by the a d be detached f certificate has been si irector, page 2 should To the Hospital or Attanding Physician: "
within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumstic event, the Modical Examinating that be notified at ence.

**Physician** 

/Medical

Physician/Medical Examiner

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Completed

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Certification: To

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Baltimore, Maryland 21215-0020

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State Registrar

DEC 1

NANCY 31. Data filad (Month, Day, Year)

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)



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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | |

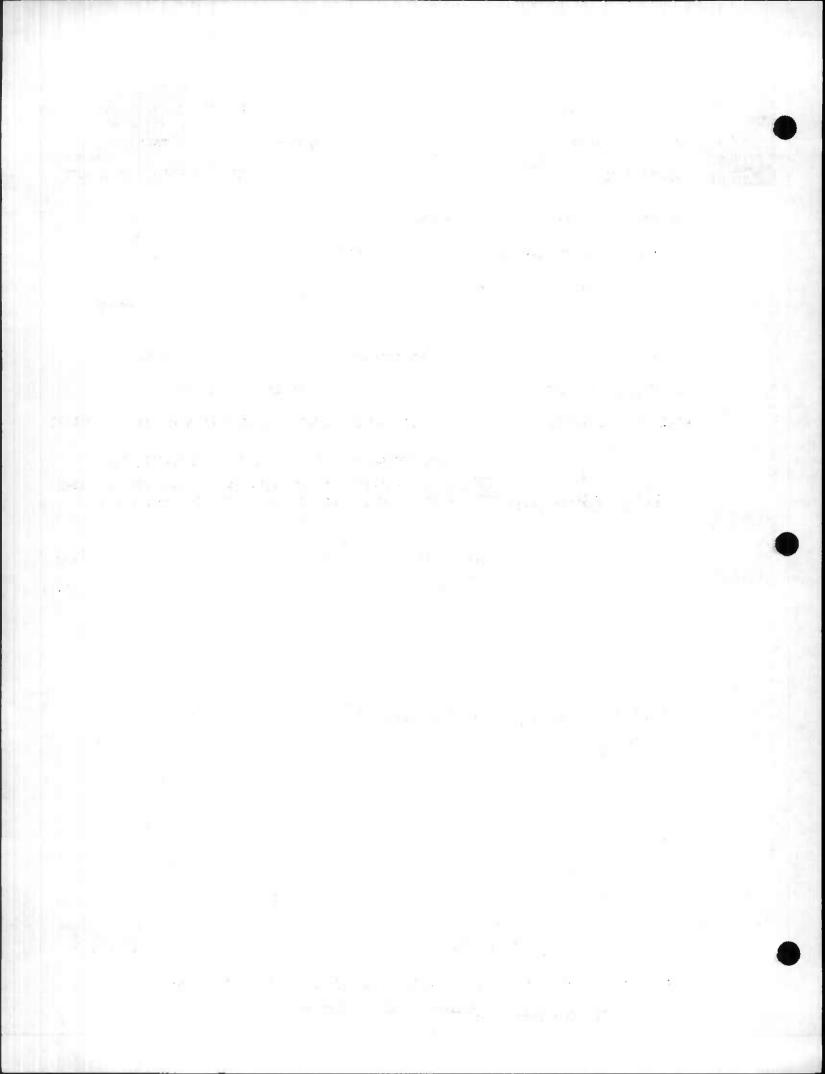
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State Registrar

31. Date filed (Month, Day, Year) DEC 3 1 1998

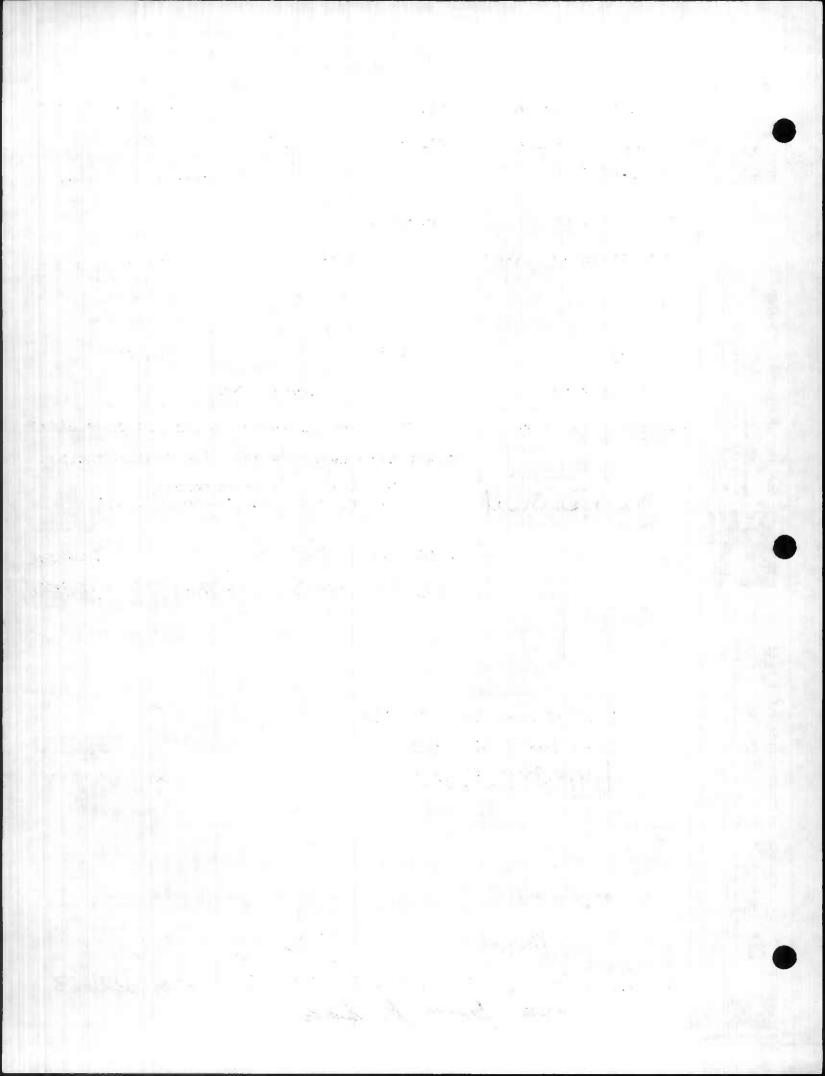


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i Au	Physicia /Medic: Examine	al	Catherine H	annah , give street end nu		Palm	er		4b. City, Town	Dec , or Location of Death		98	3:30PM
About The second			Genesis Elde	rCare -	The	Pin	es		East	ton	Та	lbo	t
	Funeral		5. Social Security Number	6. Sex	7. Age (I	in yrs. lest b	Mo	Inder 1 Year		Hrs. 8. Dete of Birth Min. (Month, Dey	Year)	9. Birth	piece (Stete or Foreign ntry)
	Director		202-01-4587 Usuel Residence of Decedent	1□ M 2□XF	89		Yrs.			MAY 5,	1909_		Md.
	ahow		10a. Stete 10b. County		10		wn or Location						10d. Inside City Limits
	M Page	Director	Md. Talbo	t		McD	aniel						Yes 2□No
	or 2	E C	10e. Streel and Number				10	of. Zip Code		1	0g. Citizen of W		ntry?
	ath v	rai	9728 Tilghma					2164			U.S.A		
	hem hem	Funeral	11. Merilel Status	12. Wes Dec	orces?	er in U,S.	13. Wes I	specify Cub	Hispanic Origin en, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)		k, White,	can Indien, etc.
20	s eff	by F	1 Never Merried 2 Merr 3 Widowed 4 Divorced	led 1 Yes If Yes, G Yeer or [	2X No		1 U Y	es 2X No	Specify:		Specify:	B18	ack
8	hou	8	15. Decedent		76169.	16	Sa. Decedent's	Lisual Occu	nation	-	16b. Kind of Bu	siness/In	dustry
2	in 72	olet	(Specify only highes	t grede completed)			(Give kind life. DO N	of work done OT use retire	during most of	f working			
21215-0020	fled within 72 hours effer death with the Meryland Hygiene. When then "natural", or flems 23s or 28s-f show ent, the Medical Examiner must be notified at	Completed	Elementery/Secondary (0-12)	College (	(1-4or 5+)		Labo	rer			Fact	ory	
D	d 2 should be filed within 72 hours effer death with the Meryfan and Mentel Hygiene.  7 is marked other than "natural", or frems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at	Bec	17. Fether's Neme (First, Middle,	Last)					18. Mother's	Neme (First, Middle, I	Maiden Sumem	9)	
Maryland	Mentel Mentel Arked o	ToB	Albert Tur	ner					Maggi	e Webb			
ary	2 should and Men is marks sumstic		19e. Informent's Neme/Reletions			19	9b. Meiling Ad	Idress (Stree		or Rural Route Number	City or Town,	State, Zij	Code)
	C = 0 L		Leonard Palme	r/ Son		9	714 Т	ilahr	nan Ts	land Rd.	McDani	e1.1	Md.21647
altimore,	8 5 2 0		20e. Method of Disposition			20b. Plece	of Disposition	(Name of		Dete	20c. Location -	City or T	own, Stete
Ĕ	Pages nent of mt: If he iry or o		N Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Si		Stete					12/30/9	Clai	bou	rne, Md.
a	Department of Important: If any Injury or pace.		21. Signeture of Funerel Service	Licansee	0		22. Ner	ne end Addr	ess of Fecility	C			
מ	SSEES		The xing	ash al	1		- 1			ral Servi		216	501
	5.50		23a. Pert1. Enter the disease, or shock, or heert feilure. List	complications that	caused the	e deeth. Do	o not enter the	mode of dy	ing, such es ca	rdiec or respiretory err	est,	210	Approximete Intervel Between
	Physician	П	SHOCK, OF REAL TENDER. LIST	only one ceuse on	eecri iirie.								Onset and Deeth
	/Medical		immediate Ceuse (Finel disease or condition		GTF H	ISKA	4128	0	SEPS	15			LINESI
	Examiner	П	resulting In deeth)	θ			e consequenc			0			, dozen
-	D 4	ne		- 4	5EU	218	RH	EUMI	ATOIL	> HRTH	21775		YEARS
	ond trans	Examiner	Sequentially list conditions, if any, leeding to immediate	D	Du	e to (or es	e consequenc	a of):					
60,	eath certificate be executed ettending physician end for use as the burial-transit	Ê	cause. Enter Underlying Cause (Disease or injury									1	
	hysic the b	dical	thel initieted events resulting in deeth) Lest	0	Due	e to (or es e	e consequenc	a of):				1	
X OX	ling p	Me		d									
ROX	ath c	lan		- 0.									
	the d	yslo	Part II. Other significant condition						iven in Pert I.	23b. Dld to	bacco uae cor	tribute 1	to the cause of death?
7.	The law requires that the death certificate tie hes been signed by the ettending physpage 2 should be detached for use as the	Completed by Physician/Media	Cocc	1GEAC	1)8	CUB	ITUS	5	155	1 U Y	08 24 No	3 ☐ Pro	obably 4 Unknown
Hecords,	sign Id be	Q P								24a. Wes e	n eutopsy		/ere autopsy findings
o S	beer	ete	LEFT	HIP F	CITC	TUPE	4			perfor	med?	C	veliable prior to ompletion of cause I death?
Š	hes ge 2	m	1416	SIDTE	ICI	AA.	/			45	o <b>⊊</b> N-		
VITAL		ပို	HY	UKIZI	V 21	010				1			☐ Yes 2☐ No
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ō	를 를 를	5 T	1 ☐ Yes 215 No 27. Menner of Deeth	28e, Dete	Inpatient of Injury	28b	Outpetient 3	28c. Inju		ng Home 5 ☐ Resid			ny)
0	Affe fune	tion	1 Neturei 5 ☐ Pendin 2 ☐ Accident investig	9	nth, Dey Y	ear)	Injury N		ork? ]Yes 2∐No				
DIVISION OF	Atten ctor	fica	3 ☐ Sulcide 6 ☐ Could I	not be 28e. Plec	a of Injury	- At home,	ferm, street, f	ectory, office				er or Rui	ral Route Number,
É	d in t	Certification:	4 Homicide	build	ling, etc. (	Specify)				City or Tow	n, State)		
	To the Hospital or Attanding i within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical		Examinar: On the b		aminetion e				plece, end due to the coccurred at the time, o			
	ithin o the ompk	Z S	29b. Signeture and title of cartified	1	statec			29c. Licen	se number		9d. Date signed	(Month,	, Day, Year)
	F 3 F 8		14	4/henr				1	126-	350	12/-	4/	98
		-	30. Neme and eddress of person	who completed care	se of dect	h (item 22e	a) (Tyna Print)		10-4		12/1	IL	10
				REMER	MD	8	00 5,	TALBE	DT ST	ST. MKHA	ELS N	DZ	1663
	Stat Registra		31. Date filed (Month, Day, Year)	3 1998	Registrer's	Signeture	B.	Space	K				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Day Vaar Physician 9:00AM DECEMBER 20, 1998 VIRGINIA M. QUINN /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva street and number) 4c. County of Death Examiner HOLY CROSS REHABILITATION AND NURSING CENTER BURTONSVILLE MONTGOMERY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) APRIL 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1 M 2 XF Months 1911 VIRGINIA 87 Director 577-09-8323 Usuel Rasidence of Deceden the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a. Stete 10b. County mant be notified at 1 Yes 2 No Directo MARYLAND | PRINCE GEORGES ADELPHI 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9400 HUGHES COURT 20783 UNITED STATES Funeral death r than "natural", or items the Medical Examiner ms 14. Rece - American indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 11. Merital Status Armed Forcas?

1 ☐ Yes ②XXNo
If Yes, Give
Yaar or Detes: filed within 72 hours aftar 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Buainass/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if itsm 27 is marked other th any hijury or other treumatic svent, the phote. 8 WAITRESS RESTAURANT 17. Fether's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumeme) Be (UNKNOWN) THORPE VIRGIS (UNKNOWN) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 9401 HUGHES COURT ADELPHI, MD 20783 ALDA POUNDS/ DAUGHTER 20a. Method of Disposition 20b. Plece of Disposition (Nema of cametery, cremetory or other plece) Data 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Ramovai from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 12/23/98 BRENTWOOD, MD LINCOLN CEMETERY 22, Neme end Address of Facility 21. Signature of Funerel Sarvice Licensee HINES-RINALDI FUNERAL HOME, INC. 9 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD20904 23a. Pert1. Enter the disaesa, or complications that causad the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximate Intarval Between Onset end Deeth Physician Immedieta Causa (Final disease or condition resulting in death) /Medical 2 WEEKS CEREBROVASCULAR ACCIDENT Examiner Due to (or es e consequence of): Examiner physician and s the bunal-transit the death certificate be executed Sequentially list conditions, if any, laeding to immediata cause. Enter Undarlying Cause (Diseese or Injury that initiated evants resulting in deeth) Lest Due to (or es e consequance of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 88 for use as signed by the a d be detached f Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Records. þ 24b. Were autopsy findings available prior to been si Completed 24a. Wes an autopay performed? completion of cause of death? s certificate has t director, page 2 s 1 Yes 2X No 1 Yes 2 No Division of Vital Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: What Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Mapner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Naturel 5 Panding I or Attendination after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be detarmined 3 Suicida 28e. Plece of injury - At home, farm, atreet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Hospital or /
 24 hours after
 Funeral Dire
 Hetaly filled in b 1 Certifying Physician: To the best of pry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signatura and titia of cartifian 29c. License number DECEMBER 21, 1998 207 callsa of Jaath (Itam 23a) (Type, Print) 30. Nema and edd s of person who complete 2309 SHOREFIELD ROAD WHEATON, MD 20902 MYRON L. LENKIN

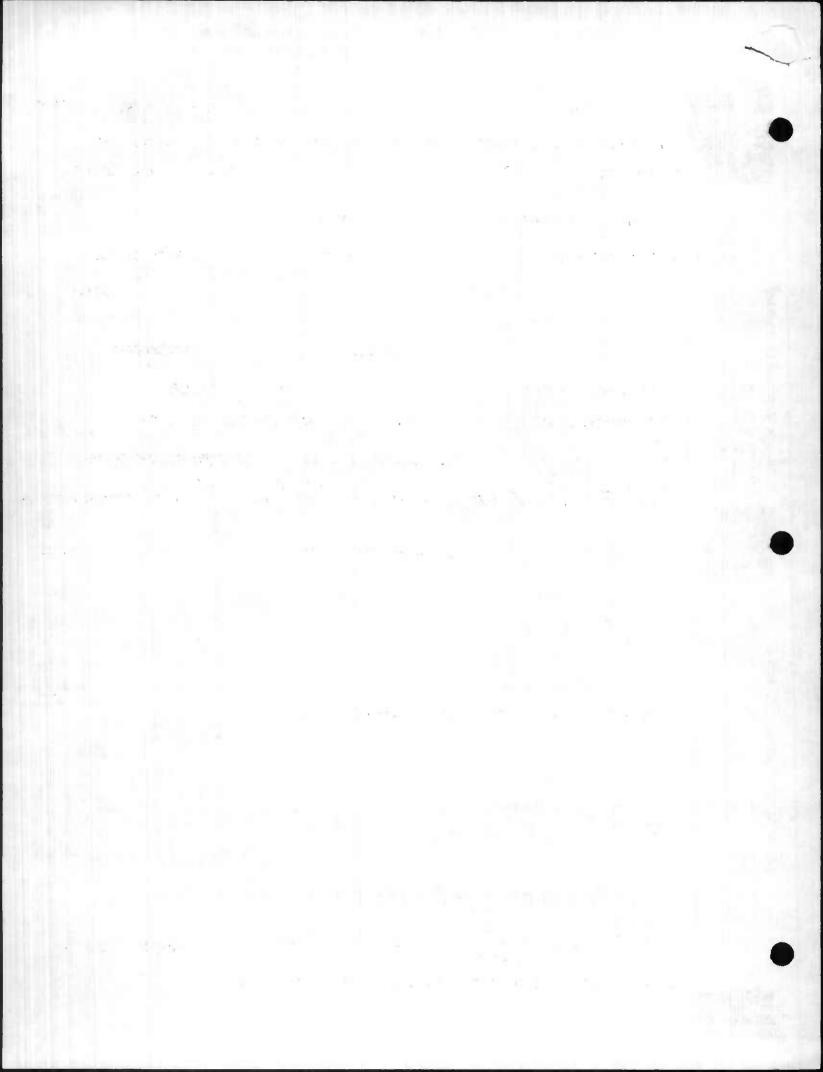
Registrar

31. Date filed (Month, Day, Year)

29

1998

32. Registrer's Signeture



1 tem#	0b,10c,10d,10e perInfG768	3 2/9/99 EW	Cer	tificate of	Death	Reg.	No.		60			
.alaian	Decedent's Name (First, Middle, Last)	- 1 -			2.	Dete of Death Month	Dev		me of Death			
/sician ledical	1 00111	askin					B, 1	. 998 6	:57 AM			
aminer	Fecility Neme (If not institution, give stree	t and number)			4b. City, Town, or Local	ion of Death	4c. County	of Death				
	Suburban Hospita S <b>b:A/S-07/NorMar</b> 6.Sex		e last histhday)	ff Under 1 Year	Bethesda If Under 24 Hrs. 8.	Date of Birth	Mont	gomery	tata as Fassian			
eral tor	578-48-4959 10 M		s. <i>last birthday)</i> 3 4 Yrs.	Months Days	Hours Min. S	Dale of Birth (Month, Day, Ye ept 24	1914	9. Birthplece (S Country) Maryl	and			
	suel Rasidence of Decedent					or		1,42,12	4114			
2	Da. Siaia 10b. County Palm Be	each 10c. C	City, Town or Loc	Palm	Springs				ide City Limits			
Funeral Director	FL <del>Lakewortn</del>	- <del>I</del>	akewor						Yes 2 No			
	De. Street end Number 300 Village Green	Circle n <del>Creek</del> S	5.	10f. Zip Code 3 3	461		Citizen of V JSA	Vhai Country? .				
	1. Mariial Status 12. V	Ves Decedent Ever in	U,S. 13. W	Vas Decedent of I	Hispanic Origin? (Specifican, Mexicen, Puerto Ric	y Yes or No-		e - Americen Indi	an,			
	1 Never Merried 2 Married 1	☐Yes ŽINo Yes, Give		☐ Yes 2 No		uii, 0.0.,	Specify					
	3₹4Widowed 4 □ Divorced	ear or Detes:				40		Murce				
	15. Decedent's Educatio (Specify only highest grade cor	npleted)	168. Deced (Give I life. D	ent's Usual Occup kind of work done O NOT use retire	pation during most of working ad)	166	. Kind of Bu	siness/Industry				
	Elementery/Secondary (0-12)	college (1-4or 5+)			pecialist	US	Gov	ernmen	t			
	7. Fathar's Name (First, Middle, Last)		1		18. Mother's Name (F							
	Samuel Markowitz				Kraina	Kanofsky						
-	9a. Informant's Name/Relationship (Type, F	•	19b. Meilin	g Address (Street	t and Number or Rural R	outa Number, Ci	ty or Town,	Stete, Zip Code)				
20	Leonard Raskin/So		20910									
	Da. Method of Disposition III 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo		City or Town, Sta	ate								
	4 ☐ Donation 5 ☐ Other (Specify)	ey, MD										
	1. Signature of Funeral Service Gensee 22. Name and Address of Fecility Ives—Pearson Funeral Hor											
	Sur Mauleh 2847 Wilson Blvd. Arlington, VA 22201											
	3a. Part1. Enter the disease, or complication shock, a heart failura. Lisi only ona ca	ns that caused the de- use on each line.	eth. Do not ente	r the mode of dyi	ing, such es cardiac or re	espiratory arrest,		Appro intarva Onset	ximate al Between end Death			
	nmediete Ceusa (Final	C.	, C					1	Care C			
ļ	iseese or condition esulting in deeth)	٥	PSU					P	ays			
		•	(or as a consequ	Lance of):	e ~			Y	earn			
	equentielly list conditions b. —		Or es e consequ	-				1				
	equentielly list conditions, eny, leeding to immediate ause. Enter Underlying							1				
1	ause (Disease or injury c nat initieted events esulting in deeth) Lest	Due to (	or es e consequ	ence of):	***							
	<u> </u>							i				
	ert II. Other significant conditions contribu	ting to death but not re	sulting in the un	derlying cause gi	ven in Pert I.	- 1		ntribute to the ca				
						Yes	2□ No	3 Probably	4 ☐ Unknown			
						24a. Was an e		24b. Were auto	opsy findings			
						performed	I?	available completio of death?	n of cause			
						1 🗆 Yes	2	1 ☐ Yes				
ŀ	5. Was case referred to medical				26. Place of Death (C		7-7-					
	examiner?	tal: 1X Inpatient 2	☐ ER/Outpatient	3□ DOA Oti	her: 4 Nursing Home		e 6 □Oth	er (Specify)				
Ì	7. Menner of Deeth 28	le. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. inju Wo		l. Describe how i						
Ceruncation:	2 ☐ Accident invastigation		,		]Yes 2□No							
	3 Suicide 6 Could not be datermined 28	le. Plece of Injury - At building, atc. (Spec	homa, farm, stre	et, factory, office	28f	Location (Stree City or Town, S		er or Rural Route	Number,			
+	9a. Certifying Physician	t: To the heet of my bo	rowledne deeth	occurred at the ti	ma data and place and	dua to the caus	a(s) and ma	nnar as stated				
	(Check only 2 Medical Examiner: 0	on the basis of axamin and mannar stated.	nation and/or inv	estigation, in my	opinion, death occurred	at tha tima, data	and place,	and dua to the ca	iuse(s)			
E	b. Signature and little of certifiar			29c. Licens	se number	29d.	Dala signed	d (Month, Dey, Y	ear)			
	DW. Act Co	hen ms		DI	t2051 (1	MD)	12/3	18 98				
Į.		A	m 22a) /Tuna E	Print) D. SC	of Cohe	M MAD		•				
	Name and address of person who comple	ted cause or death (life	1171	- 77	A	112	200	OK				
State	5454 Wiscomple Sate filed (Month, Pay, Year)	AVC #	F 1125	Che	vy Chase	MD	208	75				

T1890 CW/14/34/84

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physician	ı
/Medical	l
Examiner	I
Examine	ł

**Funeral** Director

the Maryland with "natural", or items 23s or edical Examiner must be

Pages 1 and 2 should be filed within 72 hours after deeth neat of Heelth and Mental Hygiene.
ment of Heelth and Mental Hygiene.
mit: If term 27 is marked other than "naturat", or frems 23, mit: If term 27 is marked other than "naturat" or other traumatic event, are healted Exercise mainty or other traumatic event, are Nealted Exercise mainty. Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

P.O. Box 68760. 88 USe a signed by the a d be datached t Division of Vital Records, been sign certificata has t Attending Physician: this funeral death. or Attence ofter deatl Director: 24 hours efter Funeral Dire letaly filled in b To the To the To the

physiclen and the burief-transit the death certificate be executed

1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Margaret I. Riley 5:15 PM 23, 1998 December 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Deeth Shady Grove Adventist Nursing Center Rockville Montgomery If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthpiace (State or Foreign Country) 1 □ M 2 X F Months 217-32-2035 Dec. 18, 1936 Maryland Usuat Residence of Decedent 10e Stete 10b County 10c. City, Town or Location 10d. toside City Limits 1 Nes 2 No Directo Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 905 Lewis Avenue 20851 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritei Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: p 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementery/Secondary (0-12) Cottege (1-4or 5+) Public Schools Cafeteria Manager 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Jacob E. Harmon Viola Mills 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William C. Riley, Jr./Son 905 Lewis Avenue, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 29, 1998 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signatur of Funeral Servica Licensee

Robert A Fumphirey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate intervat Between Onset and Deeth There Immediate Cause (Finet disease or condition resulting in death) · Alnta Ringl AY Due to (or es e consequenca of): Examiner DJIV Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medicai venou Que to (or es e consequence ol): 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 4 p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed Vaucalas 1 Yes 2 No 1 Yes 2 No 1 tast 1 m 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of tnjury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title ol certilier MO 031839 10 mbor 28, 1998 musto 30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print) 615 West montgomary

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Rucku.

W/ 10

2085

C. Ountor

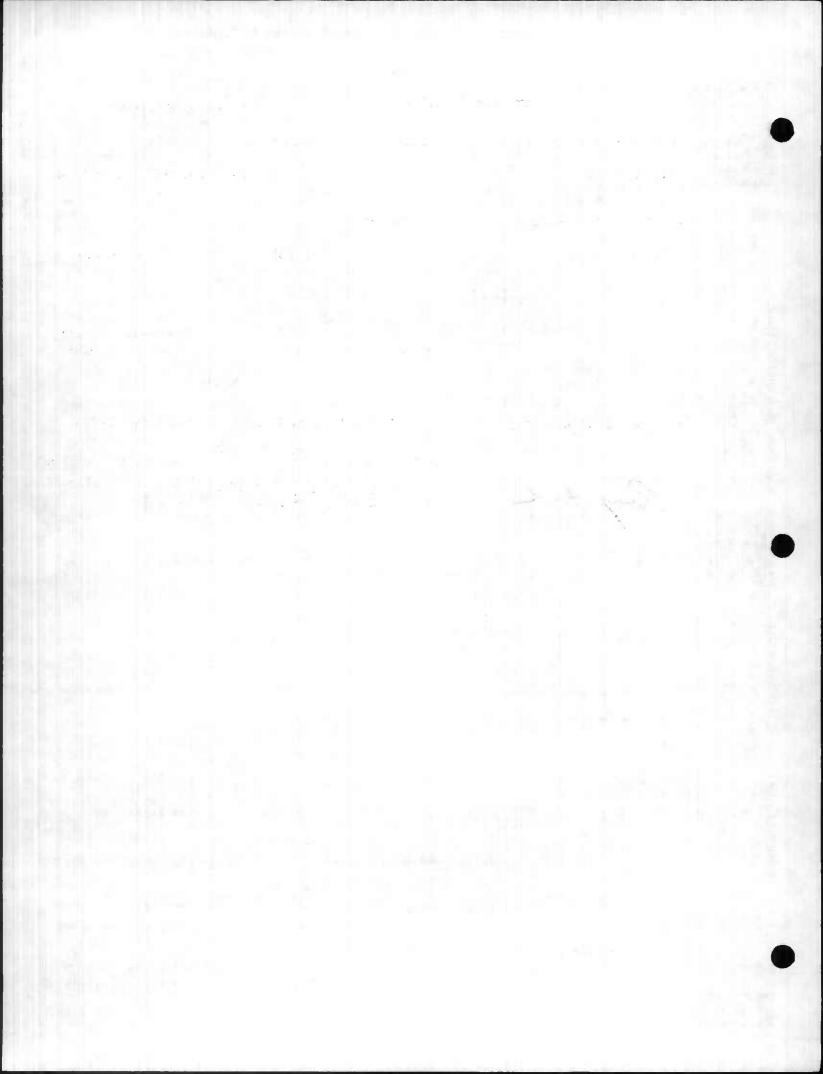
32. Registrer's Signature

State Registrar

+ 0

Chris 31. Date filed (Month, Dey, (dar)

ph



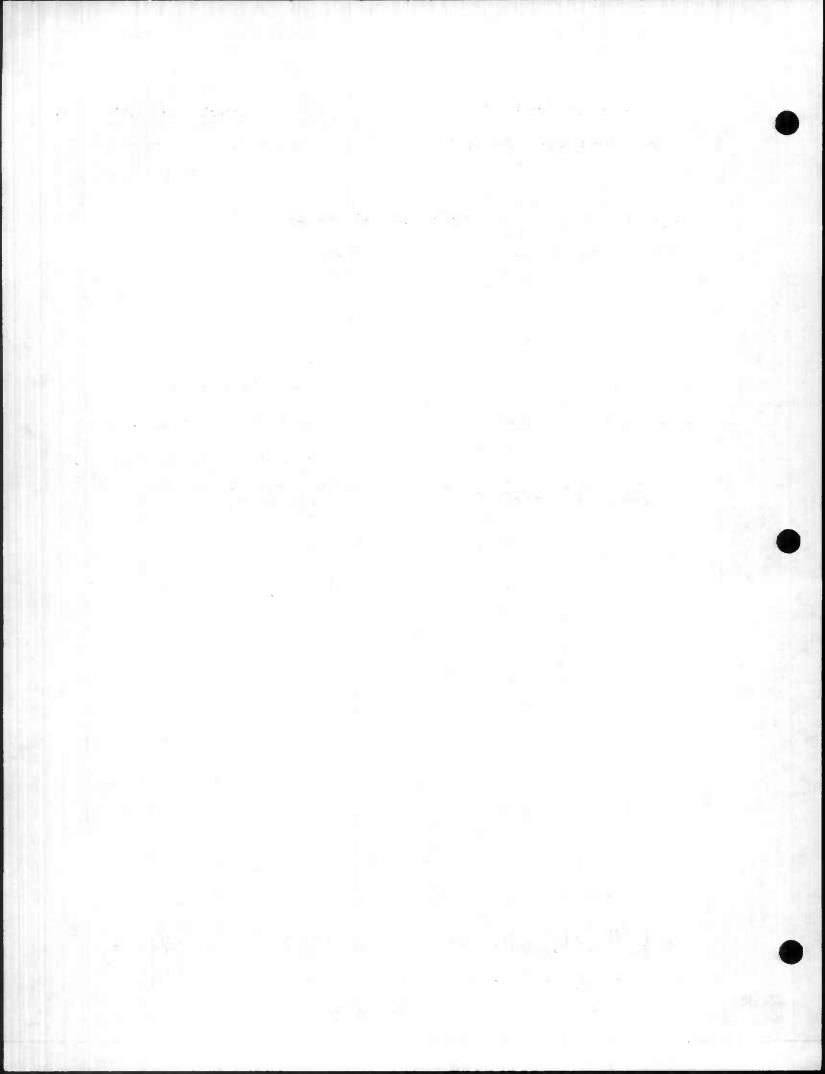
					State of	Man	yland		artment ertificate		lealth and I Death		giene O	4	30%	
	Physician · /Medica	n	1. Decedent's Nam	e (First, Middle, Las e Lincoln		,						2. Date of Dec Month Decembe	Day	Year 998	3. Time of Death 7:30 AM	
	Examine		4a Facility Name (I	fnot Institution, givensby Road		n <i>ber)</i>					4b. City, Town, or I	ocation of Death		of Death	3044	
_	Funeral Director		5. Social Security N 216-46-7	umber 6. S 329		7. Age (i	In yrs. las	st birthdaj Yrs.	/) If Under 1 Months	1 Yaar Days	If Undar 24 Hrs. Hours Min.		h		aca (Stata or Foreign try) lington, Do	
	ter deeth with the Maryland items 23s or 28s-f show free mass be notified at		Usual Residence of 10a. State MD	10b. County  Montgon	nerv	1		Town or I	ocation Sprin	12				10	0d. Inside City Limits 1 ☐ Yas 2 ☒ No	
	or 28	Director	10e. Street and Nur	mber					10f. Zip (	Code	110		10g. Citizen of		try?	
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert										my opinion, death occurred at the time, date and place, and dua to the cause(a)			the cause(a)		
	40	29b. Signature and title of cartifier  Neutron - Shayeld								29d. Data signed (Month, Day, Year)						
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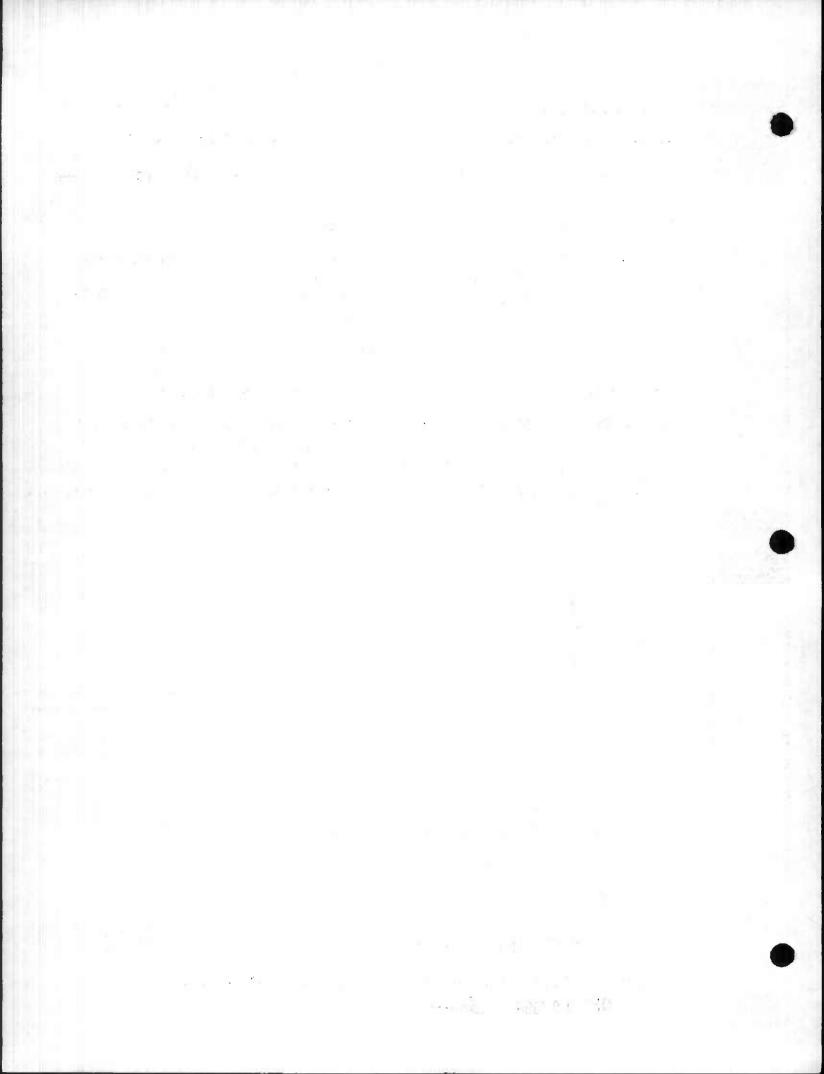
State of Maryland / Department of Health and Mental Hygiene 98 1363

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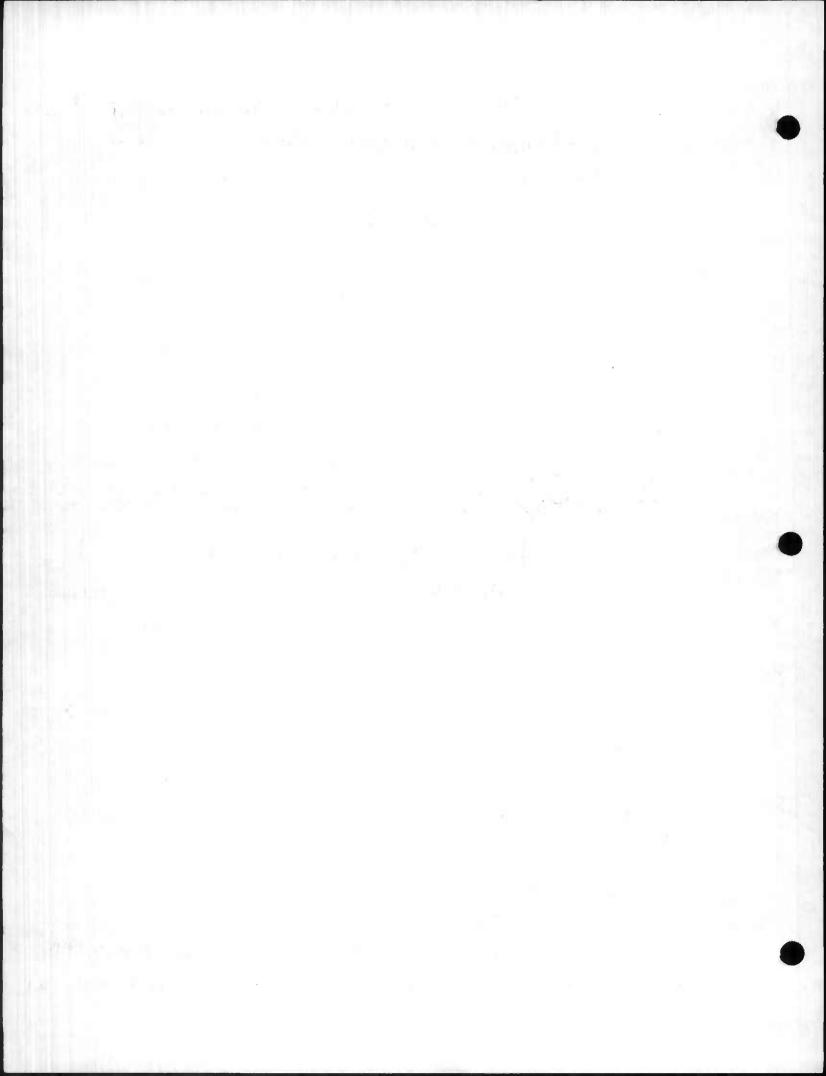


State of Maryland / Department of Health and Mental Hygiene

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		Caroline Nurs	ing Home	e				D	entor	n, Ma	ryland	l Ca	roline		
neral		5. Social Security Number	6. Sex		e (In yrs. lest b	irthday)	If Under			24 Hrs.	8. Dete of B (Month, D	irth	9. Birth	placa (S	Stata or Foreig
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O. Box 6 Ne death certification in the attending property is a page of the state of	09	Part	. Other signifi	cant conditions co	d	ut not rasulting	g in tha und	arlying causa g	ivan in Part I.	23b. Did	tobacco use co	entribute to	the cause of death?
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DIVI To the Hospital or Att within 24 hours efter d To the Funeral Direct	edical C		Cartifiar (Check only one)	Certifying Phy December 2 Madtcal Exam	rsician: To the best of iner: On the basis of and mannar st	f axamination :	ige, daath o and/or inva	eccurred at tha t stigation, in my	ime, date and piece opinion, daath occi	e, end due to the urred at tha tima,	cause(s) and m data and placa,	annar as sta and dua to	ated. the causa(s)
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The second second	istrar			DEC 16		reneva	19	· Soo	uln				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month Year 19, Luther Marshall Rafter Dec. 1998 2:15 PM /Medical 4a. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hills - Genesis Eldercare Queen Anne's Centreville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 220-09-7399 Yrs. 78 Director MD Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. inalde City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 205 Armstrong Avenue Funeral U.S.A. 21617 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decadent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry should be filed within 7: and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Self. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Sumame) ant of Health and Mental H t: If item 27 is marked oth y or other traumatic even Be Pages 1 end 2 should be nent of Health and Mental Marshall J. Rafter Emma Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Route Number, City or Town, Steta, Zip Code) Roy W. Rafter - Brother 1706 Bayside Drive, Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crametory or other place) Dec. 23, 1998 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Ctr. LLC. Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home PA Pert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medicai Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting In death) Examiner Examiner Chance obstructing Pulmonony Disease.
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or Injury transmittated events resulting in death) Last Box 68760 orse turnte NO Physician/Medical Due to (or as a consequence of) the P.O. 1 Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by 1 PYes 2 No 3 Probably 4 Unknown De hydration, 11+3 tong Hypur Lucien, 14:5 long Records. þ 24e. Wes an autopsy performed? 24b. Were eutopsy findings avaliable prior to Be Completed OF. CEREBUVAScular Herrelant with Right Hemphrese completion of cause of deeth? And Aphasin, & BAcis ABuse, 1/13 fory of Bigh A K Augustian Yes

25. Was case referred to medical

26. Place of Death (Chack only ona) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pt n 24 hours after death. e Funeral Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No None 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Spacify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homlcide within 24 hours a To the Funeral D completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier Medical To the

29c. License number

, 944 WAShington Ave, Chestentown Mp 2420

29d. Date signed (Month, Day, Year)

12/21/98

State Registrar 29b. Signature and Title of certifier

31. Date filed (Month, Dey, Yaar)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

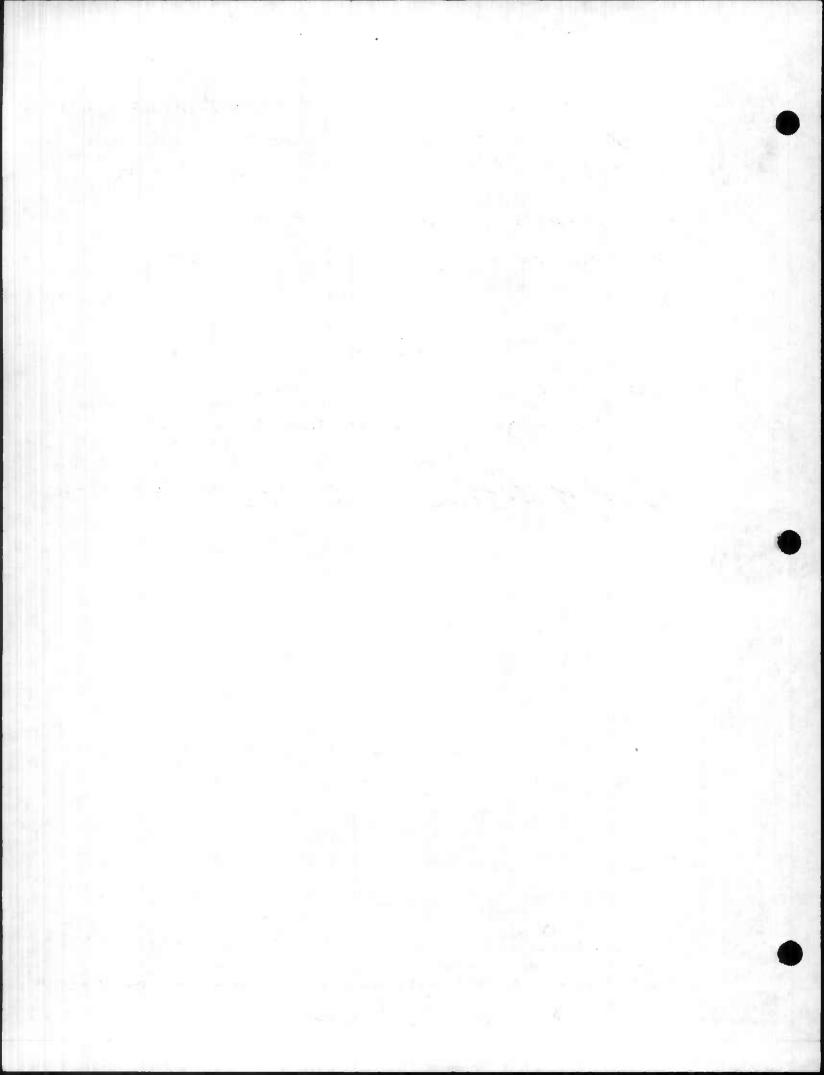
32. Registrar's Signature

JOhn C- ARRHBAL TR M-D

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Vital

**DHMH 16 Rev 6/95** 



, Amond #1 1	2/29/09 DMW Mon		and / Department o			20 13	1367			
Amena #1,1	.2/28/98, BMW, Mon 1. Decedent's Name (First, Middo	<u> </u>	Och incate t		Reg. N 2. Date of Death	10.	3. Time of Death			
Physician			SCHNEIG	DER		1998 Year	12:20AM			
/Medical	S. JOS 4a Facility Name (If not institution	eph	0011.101	4b. City, Town, or Loc		Ic. County of Death				
Examiner	Suburban Hosp			Bethesda		Montgome	rv			
Funeral	5. Social Security Number	· · · · · · · · · · · · · · · · · · ·	yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs.	0					
Director	057-18-04544	15℃M 2□ F 77	Yrs. Months De	ays Hours Min	8. Dete of Birth (Month, Day, Yea Aug. 15,	1921	nplace (State or Foreign unity) New York			
2 .	Usual Residence of Decedent  10a. State  10b. Count	100	. City, Town or Location				10d Incide City I leade			
vith the Marylar or 28=4 show be notified at		itgomery	Bethesda				10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
\$ 0A D	10a. Street and Number 8014 Aberdeen	Rđ.	10f. Zip Coo 20	0814	10g. C	Citizen of What Cou US	intry?			
5 22 5	11. Marital Status  1 Never Married 2 Mei 3 Widowed 4 Divorce	If Yes Give	If Yes, specify (	of Hispanic Origin? (Spec Cuban, Mexican, Puerto R No Specify:	cify Yes or No- lican, etc.)	14. Race - Ameri Bleck, White Specify: Wh:	, etc.			
hour threat		nt'a Education	16a. Decedent's Usuel Oc	ecupation	16b.	Kind of Business/Ir				
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygions. mportant: if Itam 27 is marked other than "natural", or he my injury or other traumatic avent, the Medical Examination. To Be Completed by Fu	(Specify only higher Elementary/Secondary (0-12)	college (1-4or 5+)	(Give kind of work do life. DO NOT use re Systems Ana	one during most of workin ntired)	IBM  The (First, Middle, Maiden Sumeme)  Macy					
ind 2 be filed tal Hygin d other avent, B	17. Fether's Name (First, Middle		- Dyouchio Inio		(First, Middle, Maide	/				
arylan should be marked o umafic ave	Edward Schne	eider		Dora	Macy					
Maryland 2 nd 2 should be filed the and Mental Hygis 27 is marked other r traumatic avent, To Be Co	19a. Informent's Name/Reletion			reet and Number or Rural		acy  aber, City or Town, Stele, Zip Code)  , Md. 20814				
ore, Mass and 2: of Health ar Hem 27 la	Ruth Schneider	:/ Wife	8014 Aberd	deen Rd. Bet	hesda, Md	CY or, City or Town, State, Zip Code)				
more, I Pages 1 and Nent of Healt nit: if Nam 27 iry or other in	20a. Method of Disposition  1 Burial 2 Coremetion  4 Donation 5 Other (3	3 □Removel Irom State	bb. Place of Disposition (Name of cemetery, crematory or other Mt. Comfort Cre	place)						
Baltimol pemit. Pages Department of important: if it any injury or o	21. Signature of Funeral Service	Licensee		Sagel Funera						
Jun 88 E 8 8	23a. Part1. Enter the di ease, o	complications that caused the conly one cause on each line.		ckville Pike dying, such as cardiac or		e, Md. 2	Approximete			
Physician /Medical	Immediate Cause (Finel		RATORY FA				Interval Between Onset and Death			
Examiner 5	disease or condition resulting in death)	Due	no (or as a consequence of):	1100110						
D, assected in and riel-transit	Sequentially list conditions	0.	to (or es a consequence of):			+				
1/98 /224M  Box 68760, death certificate be associed e attending physician and bot for use as the burist-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	BRONCI		ARCINO	NA					
V 0 80 0	Cause (Disease or injury that initiated events resulting in death) Last	C. Due t	o (or as a consequence of):	1101.001	71					
Med Med	Toodking in ooder, case									
Box 6 Box 6 sath certific true as for use as		d		100						
(B) PLO. Box 68 is that the death certificationed by the attending phis deteched for use as the by Physician/Med	Pert II. Other significant conditi	ions contributing to death but not	resulting in the underlying cause	e given in Part I.	23b. Dld tobacc	co use contribute	to the cause of death?			
P.O. P.O. that the deteching deteching of Physics					1 🗆 Yee	2□No 3□Pm	obably 4 Unknow			
Ord Ord oen s hould			M. Asi	Self-weight	24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of cau					
0 0 6 20 0					4FFW		of death?			
f Vital Recystolan: The law yatclan: The law director, page 2	25. Was case referred to medica	st				20(No 1	Yes 2 No			
	examiner?	Hoenital:	оП FD(0, 4-45-4, оП D04	26. Place of Death Other:		с Поњ., (С	14.3			
0 5 5 7	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 3 DOA 28b. Time of 28c.	4 Li Nursing Horr	ne 5 Residence 8d. Describe how in		vry)			
der vision of vi	1 Accident 5 Pendi	ng (Month, Day Yea igation		Work? 1 ☐ Yes 2 ☐ No						
N 500 5	3 ☐ Suicide 6 ☐ Could	not be nined 28s. Place of Injury - / building, etc. (Sp	At home, larm, street, lactory, off ecify)	lice 2	81. Location (Street City or Town, Sta		ral Route Number,			
Hospi 24 hour Funer stely fill dical		ng Physician: To the best of my Examiner: On the basis of exam and manner steted.								
within Within Comple	29b. Signature and this of certific		29c. Lic	cense number	29d. [	Dete signed (Month	n, Day, Year)			
0 10		vgv, mo	D.	26571	12	121/98	3			

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DHMH 15 Rev 6/95

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(RVING MIZUS, MD 4930 DEL

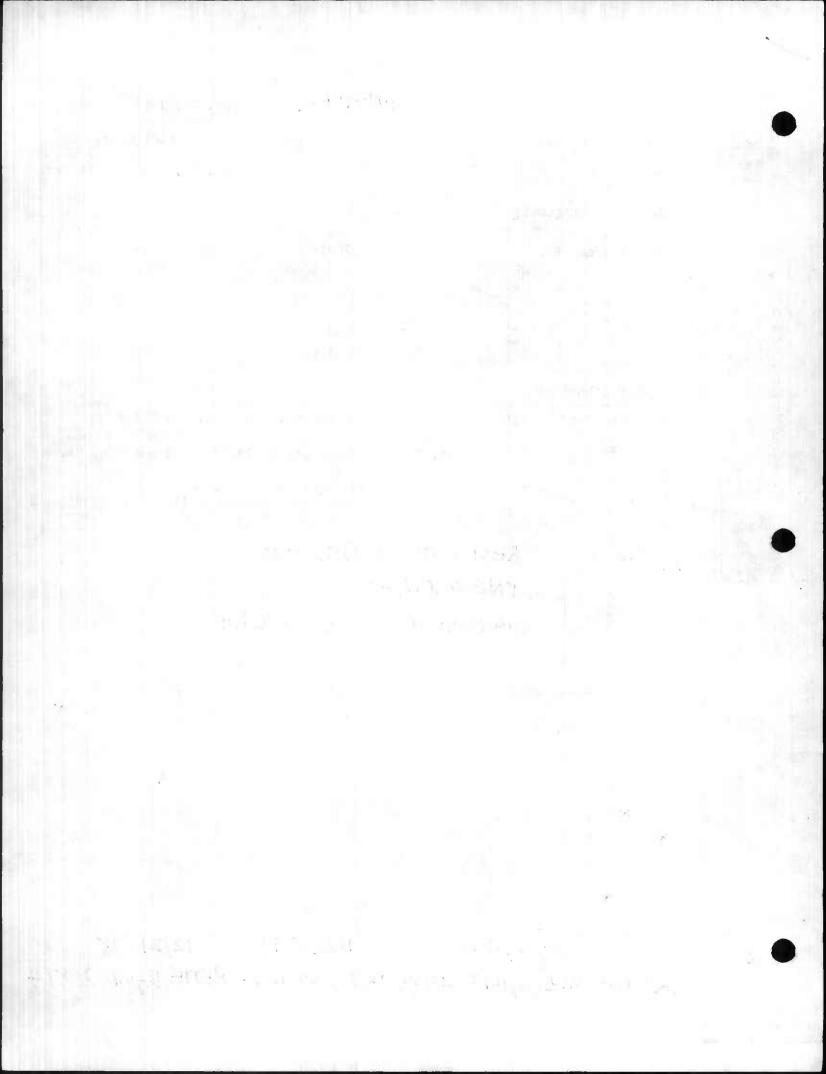
31. Date filed (Month, Day, Year)

DEC 28 1998

32. Rigistrar'a Signature

4. Apa

RAY AVE BETHESDA, MD 20814



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Dete of Deeth December 22, 1998

**Physician** · /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic avent, the Medical Examinal must be notified at obse.

Physician /Medical Examiner

physician and s the burial-transit The law requires that the death certificate be executed P.O. Box 68760, attending pl signed by the Division of Vital Records, should should is certificate has director, page 2 After this funeral ector: by the

Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica To the Hospital or within 24 hours aft To the Funeral Di completely filled in 10+

1. Decedent's Nama (First, Middla, Last) Richard James Sample 7:54 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 118 Monroe Street #702 Rockville Montgomery If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (in yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 10xM 2□ F Months Days Hours Min Yrs. 217-44-0184 80 December 15, 1918 Indiana Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 118 Monroe Street, #702 20850 United States Funeral 12. Wes Decedent Ever In U.S.
Armed Forcas?

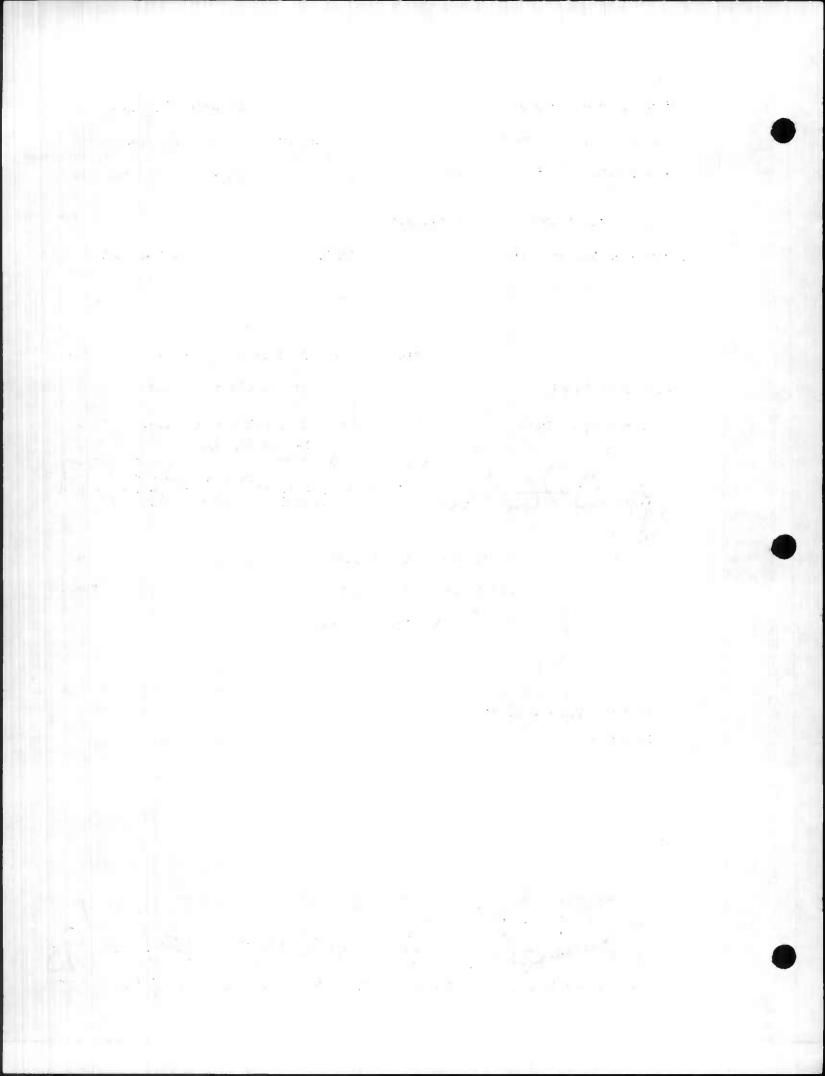
1 (X)Yas 2 (1) No World
If Yes, Gwa
Yaar or Datas: War II 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) Bleck, Whita, etc. 1 Navar Married 2 Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Transportation Specialist 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) Harry Paul Sample Nellie Clair Hission 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 118 Monroe Street, #702, Rockville, MD 20850 A. Marie Sample/ Wife 20b. Placa of Disposition (Nama of cematery, cramatory or other place) December 24, 1998 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 ☐ Buriai 2 X Cramation 3 ☐ Ramovel from Stata Montgomery Crematorium, Inc. 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Lice se 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00689 En / the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or leaf failure. List only one cause on each line. Approximsta Intervsl Batween Onset end Deeth Immediata Causa (Final Congestive Heart Failure Weeks Dua to (or as a consaquance of): Examiner Old Myocardial Infarct Years Sequantially list conditions, if any, leading to Immadiata cause. Entar Underlying Causa (Disassa or Injury that initiated evants rasulting in daath) Last Dua to (or as s consequance of): Coronary Arteriosclerosis Physician/Medical Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown Chronic Renal Failure à 24b. Wara sutopsy findings availabla prior to completion of causa of death? Completed Emphysema 24a. Was an sutopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Nesidence 6 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Daath 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide I⊠ Certifying Phy ictiv: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the difference of 29a. Certifier. Medical and dua to the cause(s) 29d. Data signed (Month. Da 29b. Signeture end title of certifie 296. License numbar o computed cause or yearn (item 23a) (Type, Print) 30. Nema and addrass of person v 15235 Shady Grove Road #100, Rockville, Maryland Barton J. Gershen, M.D. 20850

**DHMH 16 Rsv 6/95** 

Registrar

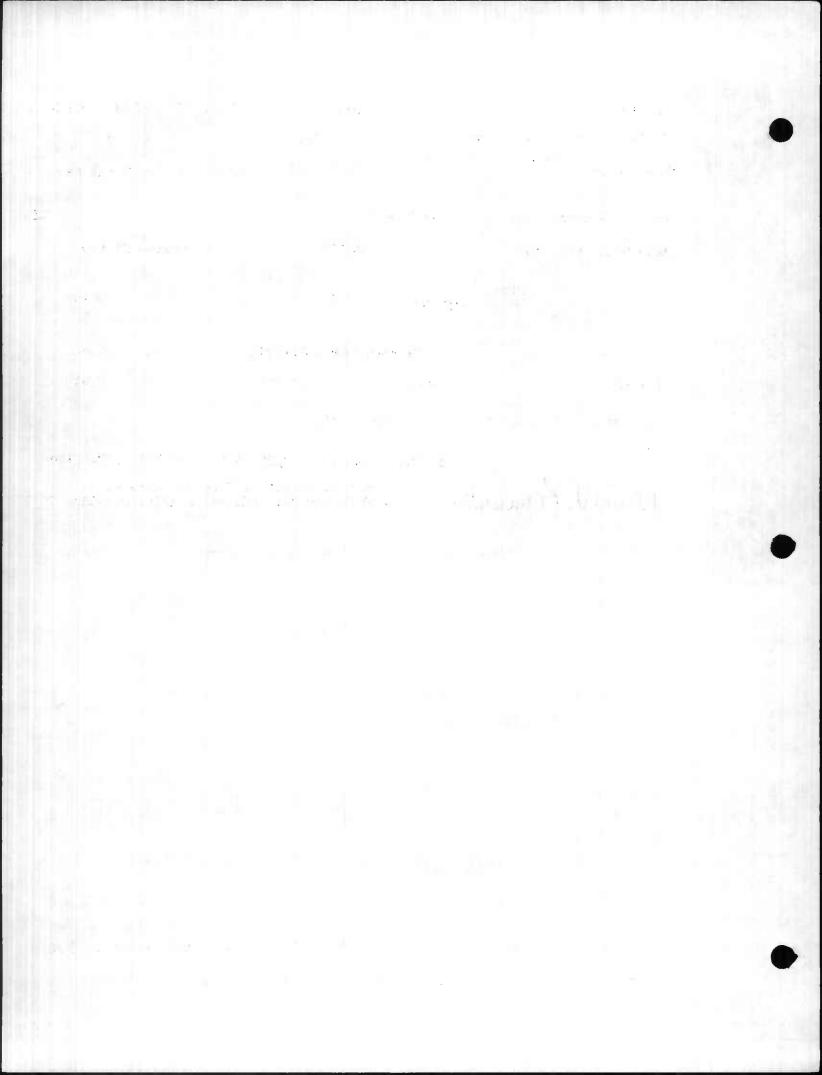
31. Data filed (Month, Day, Year)
DEC 28

32. Registrar's Signature



## Facility Name (First Institution, give stream of number)    13400 Rich Lynn Court   10.0000000000000000000000000000000000		1. Decedent's Neme (First, Middle, Las	st)					2. Dete of De			Tima of Death	
13400 Rich Lynn Court    Highland	cal _				Sc			Dec.	23, 19	98	6:30A.	
5. Social Security Number 413—42—668 Yrs.  Market Stellar (North Cale) Year (North C	ner '	A STATE OF THE PARTY OF THE PAR										
10e. Steele   10e. County   10e. Celty, Town or Location   10e. Taylor Count   10e. Celty, Town or Location   10e. Street and Number   13400 Rich Lynn Court   10f. Zep Code   20777   10e. Street and Number   13400 Rich Lynn Court   10f. Zep Code   20777   10e. Celts and Number   10f. Zep Code   20777   11e. Mere Married   20f. Marri				(In yrs. lest bir	Months		If Under 24 Hra			9. Birthplece	(State or Foreign	
Maryland   Howard   Highland   1   Verification   10   California Number   13400 Rich Lynn   Court   10   California Number   13400 Rich Lynn   12   Wes Decedent   13400 Rich Lynn   12   Wes Decedent   13400 Rich Lynn   12   Wes Decedent   13400 Rich Lynn   13   13   Wes Decedent of Hispenic Origin? (Specify Yes or No. 14, Race - American Indian, Bisck, White, etc.   13   Wes Decedent of Hispenic Origin? (Specify Yes or No. 14, Race - American Indian, Bisck, White, etc.   13   Wes Decedent of Hispenic Origin? (Specify Yes or No. 14, Race - American Indian, Bisck, White, etc.   13   Wes Decedent of Hispenic Origin? (Specify Yes or No. 14, Race - American Indian, Bisck, White, etc.   13   Wes Decedent of Hispenic Origin? (Specify Yes or No. 15)   14   Race - American Indian, Bisck, White, etc.   13   Wes Decedent of Hispenic Origin? (Specify Yes or No. 15)   14   Race - American Indian, Bisck, White, etc.   15   West Decedent of Hispenic Origin? (Specify Yes or No. 15)   15   Race of No. 15   R				10c. City. Tow	n or Location					10d, 1	Inside City Limita	
Toe. Street and Number   106. Zive Code   20777   20											1 □ Yes XXNo	
Secondary   Seco	Direc	10e. Street end Number	Court					5.5	10g. Citizen of W United	That Country? States		
Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade completed   Specify only highest grade grad		1 ☐ Never Merried XX Married	Armed Forces?  XXYes 2 No		1 □ Yes			pecify Yes or No o Rican, etc.)	Blec	k, White, etc.		
William   Scott   Scott   Rache1   Myatt		15. Decedent's Ed (Specify only highest grad	ucetion de completed)	16e.	Decedent's Usu	el Occup ork done se retire	pation during most of wo	rking	16b. Kind of Bu	siness/Industr	ту	
William   Scott   Scott   Rache1   Myatt	mo	Elementery/Secondary (0-12)	College (1-4or 5+	Ca	rpenter/G	enera	1 Contract	or	Self	Employ	red	
19b. Malling Address (Street and Number of Rural Route Number, City or Town, Stefe, Zip Code)   Ernestine J. Scott (wife)   Same as #10	Be			Scot	t			me (First, Middle	, Meiden Sumem		itt	
Taylored 2   Ceremetion 3   Removel from Stete   A   Donalion 5   Dother (Specify)   Mt. Zion Cemetery 12/29/1998   Highland, Maryland 2   21. Signsfur of Funeric Service Licespee   Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 2   23a. Part. Entar the disclese, or domplications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, interesting in deeth)   Due to (or exe consequence of):   Due to (or ex				19b				ural Route Numb	er, City or Town,	Stete, Zip Coo	de)	
22. Name and Address of Fecility  23. Name and Address of Fecility  24. Name and Address of Fecility  25. Name and Address of Fecility  26. Name and Address of Fecility  27. Name and Address of Fecility  28. Name and Address of Fecility  29. Na	-		D	20b. Piece of cemeter	f Disposition (Ne	me of other ple	ice)	Dete	20c. Location -	State		
Donald V. Borgwardt Funeral Home, P.A.  4400 Powder Mill Rd. Beltsville, Maryland 2  23a. Part. Enter the disease, or domplicificity that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest.  Approximate Intervel Betwoer Such as a consequence of the consequence				Mt. Z	ion Ceme	eter	y 12/29	/1998	Highland, Maryland			
24e. Was en eutopsy performed?  24e. Was en eutopsy performed?  24b. Were autopsy fire available prior to completion of condition of co	edicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as e	consequenca of)							
24e. Was en eutopsy performed?  24e. Was en eutopsy performed?  24b. Were autopsy find available prior to completion of card death?  1	clan/M				4 4 4 4			000 014				
24e. Was en eutopsy performed?  24e. Was en eutopsy performed?  24e. Was en eutopsy performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  1		Pert II. Other significant conditions of	ontributing to deeth but	not resulting i	n the underlying	euse gr	ven in Pert I.				16	9
25. Was case referred to medical examiner? 1   Yes   2   No								24e. Was	en eutopsy ormed?	availab	ole prior to etion of cause	
25. Was case referred to medical examiner?  1	Com							10	Yes a No	1 □ Ye	s 2 No	
1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home of Residence 6 DOther (Specify)	Be	examiner?	Hospital:			100	hae					
1 Neture 5 Pending (Month, Dey Year) Injury Work? 1 Accident Investigation M 1 Yes 2 No		TE THE ZINO	1 Li Inpatien 28e. Dete of injury	28b.		UA	4 LI Nursing I					
(a) C D Control (i)	ation		(Month, Dey	Year)								
Ö alla uu alla aata	Certifica	3 ☐ Sulcide 6 ☐ Could not be	286. Piece of Injur		erm, street, factor	y, offica		28f. Location (Street end Number or Rural Route Number,				
	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledga, deeth occurred et the tima, data and piece, and dua to the ceuse(s) and menning of axamination and/or investigation, in my opinion, daeth occurred et the time, dete end piece, and and menner steled.											
29b. Signature end title of certifler  29c. License number  29d. Dete signed (Month, Dey, Year)  MARYLAND D42452  December 23, 1998	Σ	01-	youl					2452				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Chitra Rajagopal, M.D. 18111 Prince Philip Dr., #327 Olney, Maryland 20832	:	30. Name and address of person who (	ompleted cause of de	ath (Item 23a)	(Type, Print)							

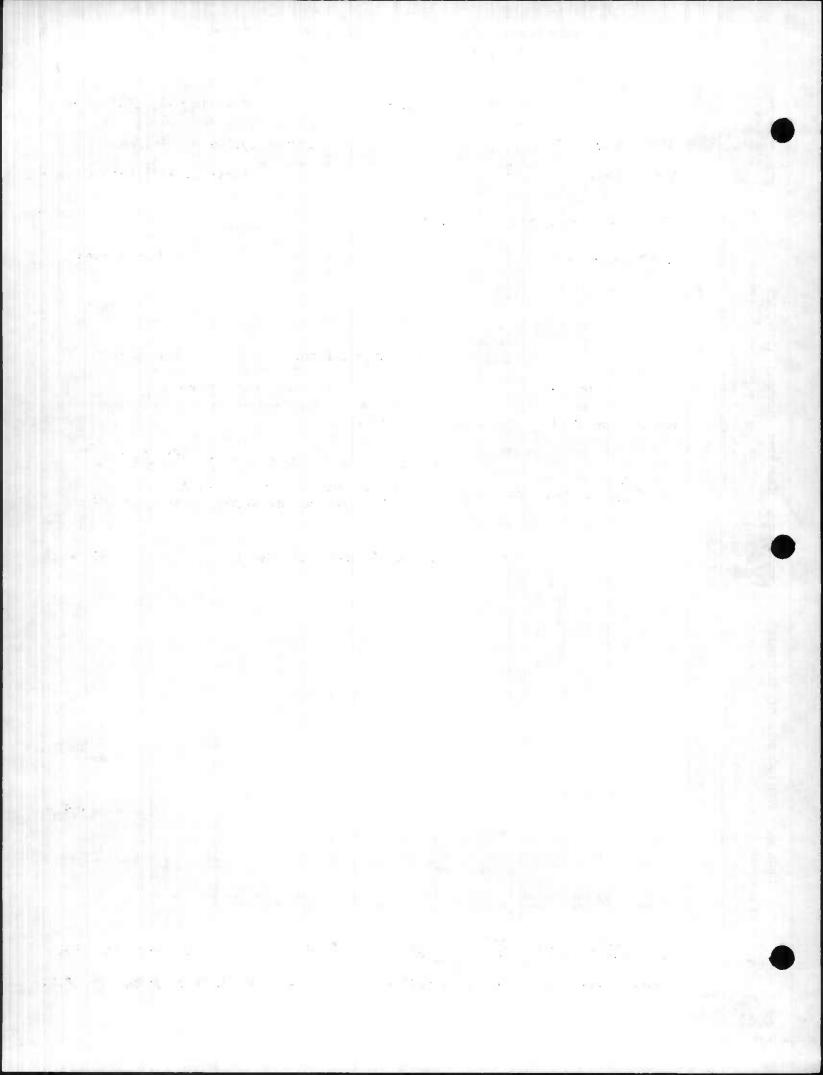
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month December 28, 1998 **Physician** 8:00 AM Nancy Jane Scott /Medical 4b. City. Town, or Location of Death 4c County of Death 4e Fecility Neme (If not Institution, give street end number) Examiner Silver S If Under 24 Hrs. Spring Montgomery 4210 Round Hill Road If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min 1□M 2以F Yrs. **Director** 60 March 2, 1938 Pennsylvania 178-30-3354 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 1 ☐ Yes 2 No Directo Pennsylvania Armstrong Apollo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zlp Code with r than "natural", or forms 23s or the Medical Examiner must be a United States death 1 Funeral 1208 School Road 15613 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indien, 11. Meritel Stelus Baltimore, Maryland 21215-0020 Bleck, White, etc. pernit. Peges 1 and 2 should be filed within 72 hours effer bepartment of Health and Mentel Hygiene. Important: if I tem 27 is marked other than "natural", or the any Injury or other treumatic event, the Medical Enatures once. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 XNo Specify: Specify. py 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Registered Nurse Health Care 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Clyde Tressler Ida May Ewing 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Robert John Scott (husband) Same as 10 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removal from State Spring Church, 4 □ Donetion 5 □ Other (Specify) Boiling Springs Cemetery 12-31-98 Pennsylvania 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Rapp Funeral Servcies, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Deeth **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical Metastatic Non-small Cell Lung Cancer 15 months Examiner Due to (or as a consequence of): Examiner physician and the buriel-trensit certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or es e consequence of): 98 use 23b. Did tobacco use contribute to the cause of death? ed by the a Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? page 2 s has 1□Yes 2♥No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Nome's 10 Hospital: 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending 1 Netural after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier Medical completely (Check only one) To the To the To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certified D 35996 December 28, 1998 da 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Linda M. Burrell, M. D., 2101 Medical Park Drive, #210, Silver Spring, MD 20902 31. Dale filed (Month, Dey, Year) 32. Registrer's Signature State 1998 Lucy

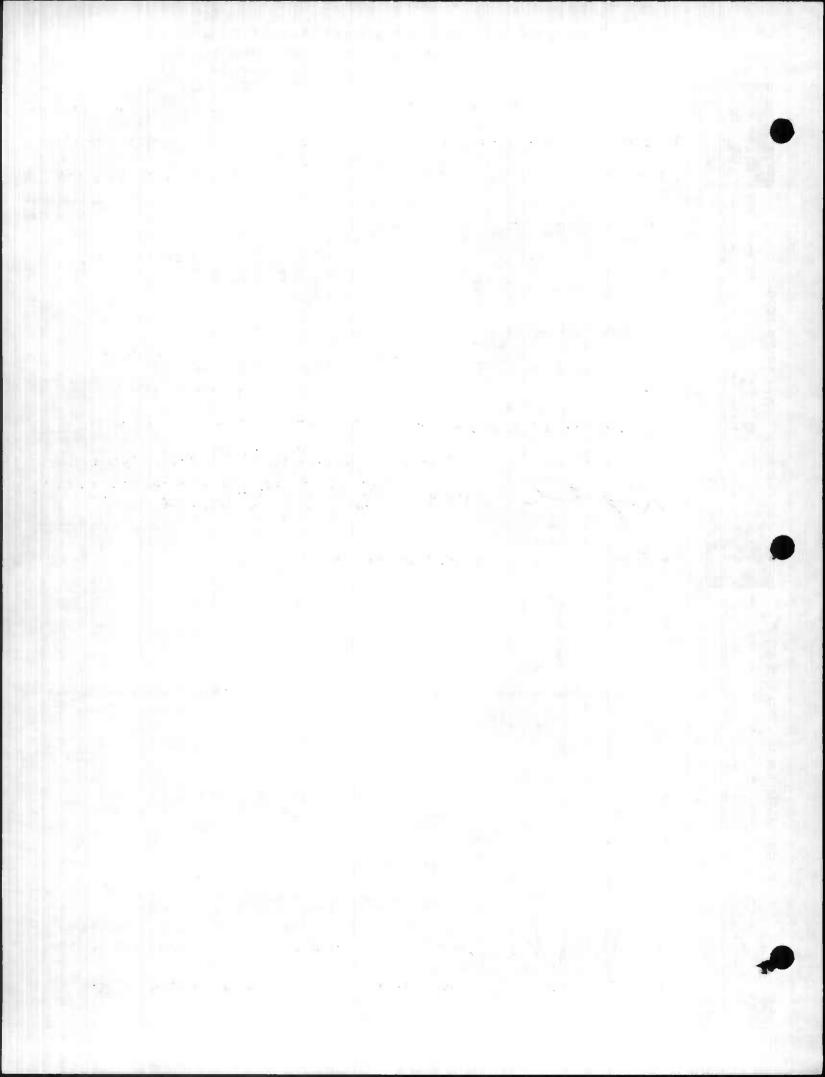


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(	Charles	Smith						]	Barbara	N. Bew	ley	
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20a	1. Method of Disp		3 □Ramovel from	State 20b. F	Plece of Dis cometery, c	sposition (Neme of rematory or other p	lece) Dec	30	Dete 1998	20c. Location -	City or Tow	n, Stata
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21.	. Signeture of Fu	nerel Service LI	censee		F	Pame and Add	ress of Faqili	rey 1	Funeral	Home/Be	ethesc	la-Chev
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29a. Certiflier (Check only one)  29a Certiflier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manipulation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and place, and due to the cause(s) and manipulation and due to the cause(s) and manipulation and due to the cause (s) and manipulation and due to the cause (s)												
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Registrar DHMH 16 Rev 6/95

Re Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

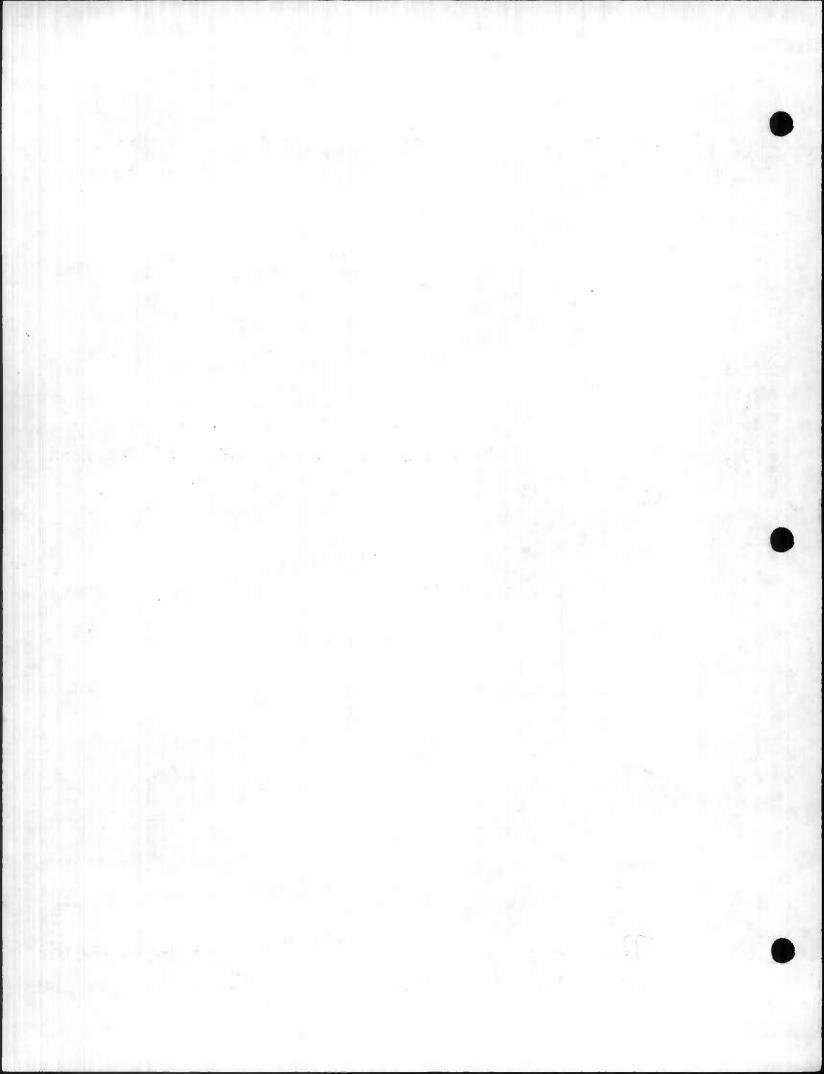


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Leonard P. Sileo Sr. December 22,1998 9:00am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY K Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 XM 2 F 70 209-18-1081 Director June 30, 1928 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Md. Montgomery 1 Yas 2 No Gaithersburg Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23a or 16640 South Westland Drive 20877 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "rany Injury or other traumatic avant. Its Elementery/Secondary (0-12) College (1-4or 5+) Auditor Federal Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Thomas Sileo Angeline Ross 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olga Sileo (Wife) 16640 S. Westland Dr. Gaithersburg, Md. 20877 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dec. 28 1998 20e. Method of Disposition 20c. Location - City or Town, State 1 N Burlel 2 Cremetion 3 Removel from Stete Silver Spring, Md. Gate of Heaven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensi les 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata tntarvat Between Onset and Deeth **Physician** Immediata Cause (Final disease or condition resulting in deeth) /Medical Ventricular Fibrillation Minutes Examiner Due to (or as a consequence ot): Examiner Congestive Heart Failure Months The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): 88 P.O. 23b. Did tobacco use contribute to the cause of death? the Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 | No 3 | Probably 4 N Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 this 28a. Date of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred To the Hospital or Attanding Pt. within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. tnjury at Work? Certification: After t 5 Pending investigation 1 Neturel 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier December 22, 1998 2 30. Neme and address of person who con Martin Miles eleted cause of death (Item 23a) (Type, Print) Medical Center Dr., Rochville MD 9901 Martin mo: 31. Date filed (Month, Day, Year) State 1998

**DHMH 16 Rev 6/95** 



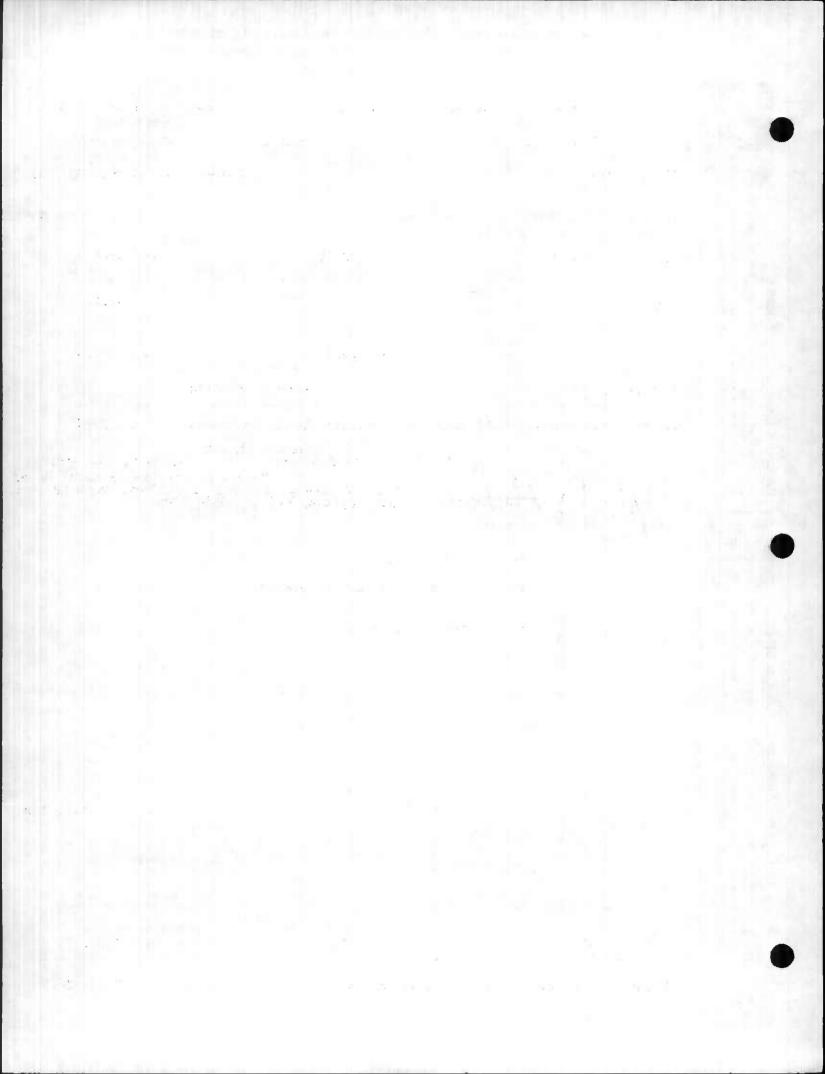
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and / Department of Health and Mental Hygiene	3	1	-
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			Ce	ertificate of	Death	Re	g. No.				
	1. Decedant's Nama (First, M.	iddie, Last)	145 115 14 16			2. Data of Death Month	Day		Time of Death		
Physician /Medical	I	Evelyn G	ohagan	Smith	I	December			6:30 PM		
Examiner	4a Facility Nama (If not institu	ition, give street end num	ber)		4b. City, Town, or Loca	ation of Death					
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Funeral	5. Social Security Number		'. Aga (In yrs. lest birthday	) If Under 1 Yaar Months Days	If Undar 24 Hrs.   8	B. Date of Birth (Month, Dey,	Yeer)	9. Birthplace	(Stata or Foraign		
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72 hours efter death with the Maryland natural', or items 23s or 28s-f show diest Examinet must be notified a steed by Funeral Director	10a. State 10b. Cou	nty	10c. City, Town or L	ocation				10d. f	nside City Limits		
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marked matic ev	Herbert P. Gol	hagan			Anna T. M	Manning					
e me	19a. Informant's Name/Ralationship (Type, Print)  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, 2										
27 r tr	Margaret Kerza-Kwiatecki/Daughter 7609 Quintana Court, Bethesda, Maryland 20a. Method of Disposition  20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Neme of cermetery, crematory or other place) December 28, 1998										
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Important: if any Injury o	21. Signature of Funeral Serv	rt A. Pumphrey Funeral Ho			ral Home						
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director.	25. Was case referred to med examiner?	Hospital:	and a Decision	Ot Ot	26. Place of Death		**		roun Home		
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the fune cation	1 XNatural 5 Par	rk? ]Yes 2□No	D0001100 110	inquity occur							
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Directify Sirtle	4 ☐ Homicide date	ermined 28e. Place of building	20	City or Town		o. or riurar no	and realizably				
To the Funeral Directo completaly filled in by the Medical Certific	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Mec Mec	29b. Signature and title of cert	d. Date signe	d (Month. Day	Year)							
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	30. Name and eddrass of pers										
	Shakunmala Gu	ipta, M.D. 1	0810 Darnest	cown Road	, #202, Ga:	ithersb	urg, MD	20878	-2675		
State	31. Date filed (Month, Day, Ye	ar) 32. Re	gistrar's Signature								

State Registrar

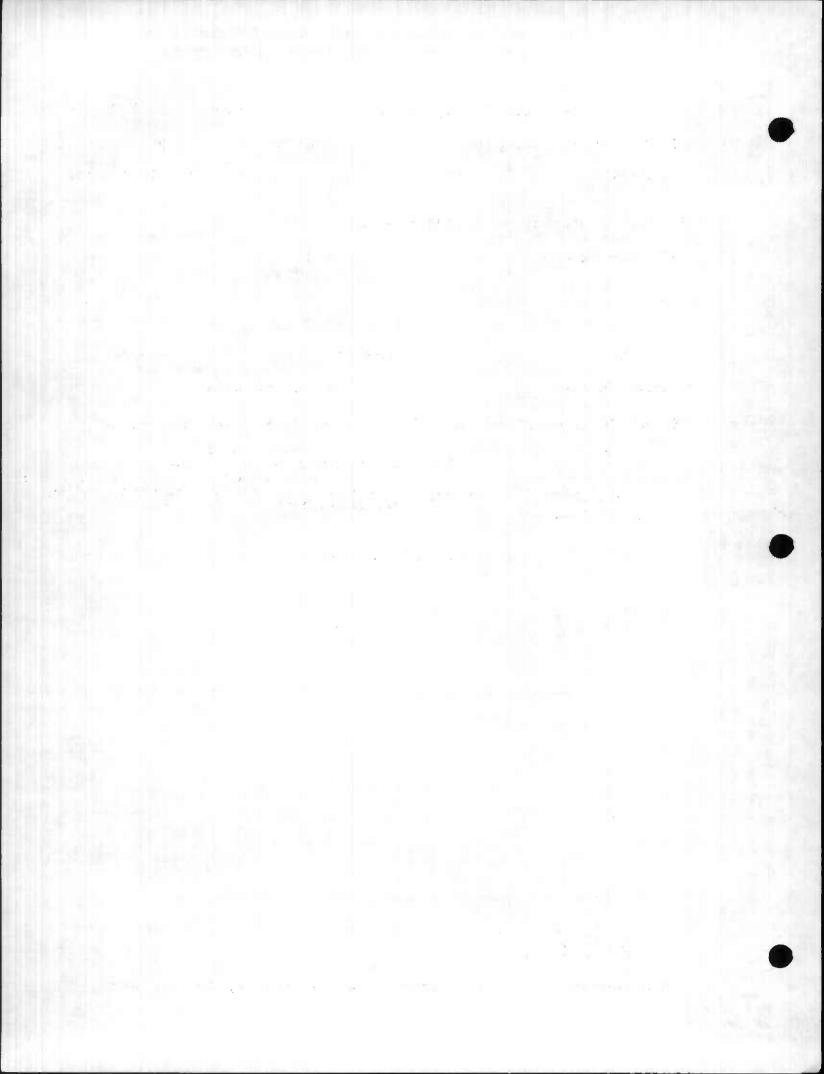
DEC 28 1998



State of Maryland / Department of Health and Mental Hygiene 2 1, 1 2 7 1,

						(	Certific	ate of	Death		Reg. No.	149	101	7
		1. Decedent's Neme	(First, Middle, Li	est)						2. Date of De Month	eth Day	Year	3. Time	of Death
Physicia /Medic			Laur	a Lucil	le Dol	ph Sp	icer			Decemb			1:40	pm
Examin		4e Feclity Name (#							4b. City, Town, or	Location of Deal	th 4c. County	of Death		
		Randolph	Hills N	ursing	Home				Wheaton		Mont	gomer	У	
Funeral		5. Social Security N		Sex	7. Age (In yi		Mont	hs Devs		(Month, Di	rth ay, Year)	9. Birthp	olece (Stete	or Foreig
Director		542-28-54	//	1□ M 20XF	102	Υ	rs.			March	7, 1896	Minn	esota	
pu &		Usual Residence of 10a. Stete	Decedent 10b. County		100.0	City Town	or Location	_				1	Od. inslde	City Limit
eho d	2													s 280 N
the N	Directo	Maryland	Montgom	ery	S	ilver	Spri	Zip Code			10g. Citizen of \	What Cour	nto/2	
4 I.Z. 15-0020  4 within 72 hours after death with the Maryland jien.  1948. And Taturel, or items 23a or 28a-f show the Mades Examinet must be notified at the Mades Examinet must be notified at the Mades Examinet must be notified.				,			101.		000					
a 23	Funeral	3912 Rick	over Koa	-	edent Ever in	11.6	12 Was Da		902 Hispanic Orlain? (S	Specify Ves or N	United		es an Indien,	
Her d	5		ed 2 Merried	Armed F	orces?	0,0.	If Yes,	specify Cul	Hispenic Origin? (S pan, Mexican, Puer	to Rican, etc.)	Bia	ck, White,		
T, or	by F	3 🖾 Widowed	110	If Yes, Gi	ive		1□ Ye	s 2 🖾 No	Specify:		Specify	Wh:	Lte	
Mail yiailid A. I.Z. 13-0020 d 2 should be filed within 72 hours aft this and Martel Hygiers. 77 is marked other than "naturel", or traumatic event, me Mad sell Exert	P		15. Decedent's E			16a. D	Decedent's U	Jsuel Occu	pation		16b. Kind of B	usiness/In	dustry.	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed		ify only highest gr	ade completed)		- (	Give kind of life. DO NO	work done Tuse retin	during most of wo	erking				
s within jiene.	EO	Elementery/Secon	ndary (0-12)	College (	1-40r 5+)		Homei	maker			Own Ho	ome		
be filed the double of other persont, m	Be C	17. Fether's Neme (	First, Middle, Las	1)					18. Mother's Ne	me (First, Middle	, Meiden Sumen	10)		
should be and Mentel marked o	0 8	George	O. Dolph						Elizabe	eth Crof	t			
d 2 should I th and Meni 7 ie marke traumatic		19e. tnforment's Ne	me/Reletionship	(Type, Print)		19b.	Meiling Add	ress (Stree	t and Number or R	ure/ Route Numb	per, City or Town,	State, Zip	Code)	7.11
		Carolyn N	M. Kidwe	11/Gran	ddaught	er 38	32 Mt	. 01n	ev Lane.	Olney.	Maryland	208	32	
of Healt Hem 2 other		20a. Method of Disp	osition		20b	Discount I	Diamonthian A	Alama at	December		00 1			
permit. Pages 1 ar Department of Hea Important: If item; any injury or other			Cremetion 3 [ 5 Other (Speci						torium,		Bethesd	o M	22212	nd
nit.		21, Signature of Fu	-		111	onego	22. Name	and Addr	ess of Facility Ro	bert A.	Pumphre	v Fiir	neral	Hom
Department in poor		1 /	14	4	MO11	26	Rockv	ille,	Inc., 3	00 West	Montgom	ery A	Avenu	e,
	23a. Pert1. Not the diffice of committee the caused the deeth. Do not enter the mode of dying, su shock, or heert feiture. List only one cause on each line.									d 20850	Approxim	nete		
Dhysisian		shock, or heer	t feiture. List only	one ceuse on	eech line.								Intervat B Onset en	etween d Death
Physician /Medical						1.	1 7							
Examiner		Immediate Cause (Finel disease or condition resulting in death)  Acute Myocardial Infarction  Due to (or es e consequence of):												S
	Jer				Due to	(or as a co	orisequence	OI).						
rificate be executed g physician and as the buriel-transit	Examiner	Conversion the ties and		b. ———	Due to	(or as a co	onsequenca	of).						
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g phy ificat	P	resulting in deeth) L	.est		00010	(0) 43 0 00	nisoquoniso .	017.						
attendin	3			d										
	Physician/M	Pert tt. Other signifi	cant conditions	contributing to d	leath but not r	esulting In	the underlying	ng cause g	iven In Pert I.	23b. Dio	I tobacco usa co	ntribute t	o the caus	e of deat
ech the	hys							.,			Yss 2□ No			
s that	by P													
Physician: The lew requires that this certificate hes been signed rail director, page 2 should be det										24a. We	s an autopsy ormed?		are autops	
lew re	Set									pon	OIIII GU	00	ompletion o	
The lev ate hes page 2	Completed									10	Yes 2 No	1 (	☐Yes 2	□ No
iclan: The		25. Wes case referr	red to medical						26 Place of De	eth (Check only				
Physician: rhis certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑		Hospital:	Inpatient 2	☐ ER/Out	nationt 3	DOA O	thor		ildence 6 Oth	or /Sneci	60)	
	-	27. Menner of Deeth			of Injury oth, Day Year)			28c. Inj		_	how injury occur		y/	
Attanding Ph r death. ector: After th by the funeral	tlor	1 ☑ Neturei 2 ☐ Accident	5 Pending investigation		ith, Day Year)	In	jury M		ork? ]Yes 2 No					
	flea	3 Suicide	6 Could not to		e of Injury - At	home, farr	m, street, fac	ctory, office			(Street and Numi	ber or Run	al Route N	umber,
2 2 2 2	27. Menner of Deeth  1 Neturel  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M  28c. Injury at Work?  1 New Year  28d. Describe how Injury  28d. Describe how								own, Stete)					
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by										anner as s	stated.			
P Ho 1 24 P	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and control of the cause (s) and co									, dete and pteca,	and due t	o the cause	e(s)	
om the									29d. Date signe	d (Month,	Dey, Year	)		
,	> Markenella							Di	09834		Decemb	er 2	4. 10	98
4		30. Neme end addre	ess of person who	completed cau	se of death (III	em 23e) /7	(VDe. Print)				Decemb	C1 Z	т, 19	70
		Barry Ros						mue	Kengingt	on Max	wland of	805		
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DHMH 16 Rev 6/95



	1 100	se Type or State		nd / D	ера	rtmen	t of h	lealth	and N	Mental Hy			1375	
					Cen	incat	e or	Death			Reg. No.			
1. Decedent's Nem					2. Dete of De Month DEC	27 <sup>Dey</sup> 199	98 <sup>Yeer</sup>	3. Time of Death 12:28 PM						
4e. Fecility Neme (#NATION		n, give street end na L MEDICA		R				-	own, or L BETIII	ocation of Deeth		of Deet	rgomery	
5. Sociei Security Number 087-14 5761		6. Sex 1⊠ M 2□ F	7. Age (In yrs		rs.	if Under Months	1 Year Deys	if Under 24 Hrs. 8. Date of Birth (Month, Dey, Young)  British (Month, Dey, Young)  December 21				plece (State or Foreign intry) ew York		
Usuel Residence of 10a. Stete Maryland						y, Town or Location					10			
10e. Street end Nur 3 Chilha		t		П		10f. Zip	Code 208.	54			10g. Citizen of Unite			
11. Maritel Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in U. Armed Forces?  1 Yes 2 NWorl  If Yes, Give Yeer or Detes: War I				10.	If Yes, specify Cub				igIn? (Sp n, Puerto	ecify Yes or No Rican, etc.)	o- 14. Rece - American Indien, Bleck, White, etc.  Specify: White			
15. Decedent's Educetion (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)					16e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire				st of work	ing	16b. Kind of Business/Industry			
Elementery/Secondary (0-12) College (1-4or 5+) 5+					Contracts Negotiator									
17. Fether's Name			2					18. Moth	er's Nem	e (First, Middle, urgeon	Meiden Sumar	ne)		
19a. Informant's Na Theresa S 20a. Method of Disp	quader			10	5 F		e Fl			re, Gait		g, l	1D 20878	

**Physician** /Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** Director

ortant: If Itam 27 is marked other than "natural", or items 23a or 28a-f ahow Injury or other traumstic event, tra Modical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. I Important: If term 27 is marked other than "natural", or items 23a or any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The lew requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicial

the Meryland

21. Signeture of Funerel Ser

Director

Funeral

by

Completed

Be

2

Examiner physician and the buriel-transit

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detached for signed by the e

page 2 should

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Medicai

Examiner Physician/Medicai g Completed Be Certification: To

Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

NON SMALL CELL LUNG CARCINOMA Due to (or es e consequence of): Due to (or as a consequence of)

disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, failure. List only one cause on each line.

M00689

Due to (or es e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

Rockville, Inc.

24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2X) No 1 Yes 2 No 25. Wes cese referred to medicel examiner? 28. Plece of Deeth (Check only one) 1☐ Yes 2☐ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27, Menner of Deeth 28h Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dev Year) 28c. Injury at Work? 5 Pending Investigation 1 Naturei 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29e. Certifier 29c. License number 29d. Dete signed (Month, Day, Year)

29b. Signature end title of certifles

RES-000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BRIAN W. MECKLENBURG,

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/

Rockville, Maryland 20850-2805

300 West Montgomery Avenue,

Approximete Interval Between Onset end Deeth

State Registrar

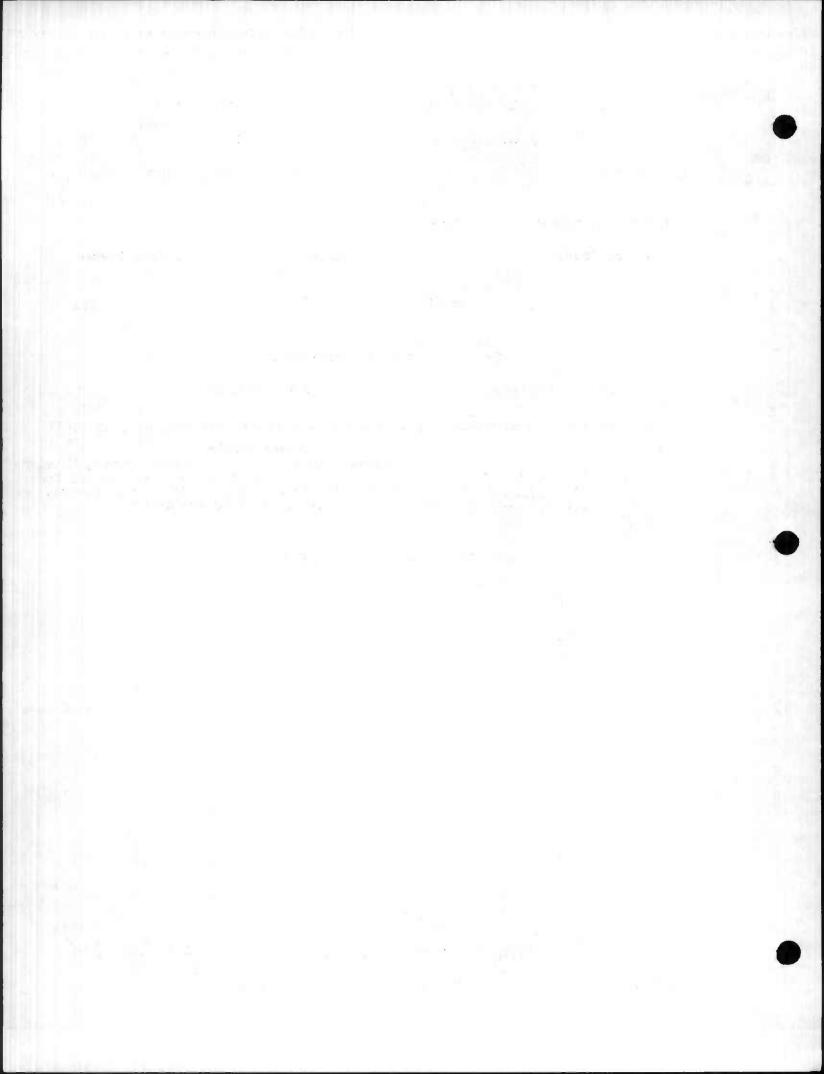
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31. Dete filed (Month, Day, Year)



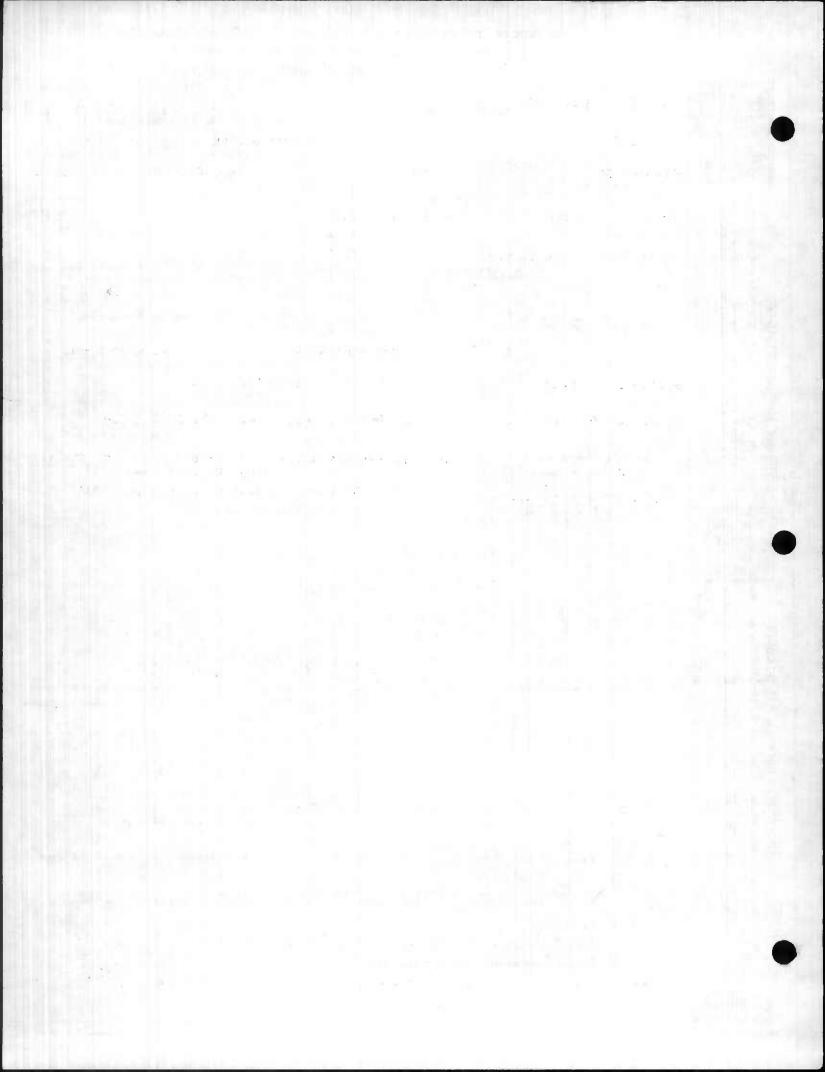


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	1. Decedant'a Nama (First, Middla, Last)									2. Data of Death 3. Time of Deeth					
Physician	MARY JANE STANTON.									Month				855pm	
/Medical Examiner	4a Facility Nama (If not institu	4	b. City, To	wn, or Lo	cation of Deat	ition of Death 4c. County of Death			1						
	Manor Care							Silve	er Sp	ring		Mont	gome	су	
Funeral	5. Social Security Number	6. Sax		Age (In yrs. le		if Under Months	1 Yaer Days	If Undar Hours	24 Hrs. Min.	8. Dete of Bi (Month, D	rth 9. Birthpi		. Birthplac	a (State or Foreig	
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*		Jsual Residence of Decedant  Oa. Stete 10b. County 10c. City, To										10d. fnside			
ral", or items 23a or 28a-f show Examiner must be notified at 1 by Funeral Director											1.02	1 ☑ Yes 2 ☐ No			
ect of	10e. Street and Number 10f. Zip Code														
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by Funeral Director	1 ☑ Nevar Married 2 ☐ P	Married	Armed Forcas?  1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates:  If Yas, specif				Specify:		Rican, etc.)	Specify: White					
8	15. Dece	dant's Education	Education 16a. Dece			edent's Usual Occupation					16b. Kind	16b. Kind of Business/Industry			
Completed	(Specify only hi		de complated)  Collaga (1-4or 5+)			(Giva kind of work dona during most of work lifa. DO NOT usa retired)			ng						
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BeC	17. Fathar's Nama (First, Mide	7. Fathar's Nama (First, Middla, Last)						18. Motha	Mothar's Nema (First, Middla,			Maiden Sumame)			
ToB	Martin J. Sta	nton						Cath	erin	ine Hines					
5	19a. Informant's Name/Ralati	lonship (Type,	Print)		19b. Maili	ng Address	s (Street	and Numbe	er or Rur	I Routa Numb	ber, City or Town, Stata, Zip Coda)				
any injury or other traumatic event, the Manage.  To Be Comp	Scott Davidso	n/Execu	utor		1761	Churc	h St	reet,	N.W	. Wash	. D.C.	. 200	036		
	20a. Method of Disposition		20b.			Pleca of Disposition (Name of camatary, cramatory or other)			laca)		20c. Location - City or		ty or Town	, Stata	
	1 ☐ Burial 2 🖾 Crameti 4 ☐ Donation, 5 ☐ Otha		ovei from Sta	ita	ropol:	711			. 1	2/27/98 Alexandria, Virgi					
	21. Signat te of Junaral San		1	1100										12-8	
BUCE	21. Signat to of Aunaral Sarvica Licensea 22. Nama and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007													07	
	23a. Part1. Enter the disease shock, or leart fair ra.	or complicati	ions that caus	sed the death										pproximate	
page 2 should be detached for use as the bunal-transit  Completed by Physician/Medical Examiner	disease or condition resulting in daeth)  Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Couse (Disease or Injury that initiated events resulting in daeth) Last	6 6 d	C	Olor Dua to (or Del	es a conse as a conse	Cas quence of):	nu	m	kg	enc	Jon	~ 5			
Cie	Part fl. Other significant con-	ditions contrib	contributing to death but not resulting in the unitarity ig cause give					ven in Part I. 23b. Di			ld tobacco use contribute to the cause of death				
y Phys	1 Yes 2 No 3									☐ Probel	oly 45 Unknow				
pleted b		1								24e. We perf	Wes en autopsy performed? 24b. Wera availe comp of dea			autopsy findings abla prior to eletion of cause ath?	
TO										10	Yas 2	No	101	res 2□ No	
Be C	25. Was casa rafarrad to med	dicai						26. Place	a of Deet	h (Check only	ona)				
To F	exeminer? 1 Yas 2 No	Hosp	pital: 1 ☐ inpa	atiant 2 🗆 E	ER/Outpatie	nt 3 D	OA Oth	er: 450 Ni	ursing Ho	me 5□Ras	idanca 6	Othar	(Specify)		
ation:	Z CI / toologitit	nding astigation	28a. Date of injury (Month, Day Year) 28b. Time of injury at Work? 28d. Describe how injury occurred												
edical Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide dat	lid not be armined 28a. Placa of Injury - At homa, ferm, straet, fectory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State)								Route Number,					
completely littled in by the funeral director, page 2  Medical Certification: To Be Comp	29a. Cartifier  (Check only one)  1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.													ed. na causa(s)	
to the Funeral Director: After completely lilled in by the funer Medical Certification.	29b. Signature and titla of gertifier 29d. Data signed (N									Month, Pa	y, Year)				
	> kut	V	Volve M.D. D2027						74	+	10	2/9	6/9	18	
	30. Name and address of per	son who comp	lated cause of	of death (Item	23e) (Type	Print)				1		1	1		
	Kicti	lohra	0 A	-			erta	O.D.	-100-	5:10	· Sa	cin	Md s	1- J090	
State	31. Data filed (Month, Day, Yo	ear)	-	istrar's Signat			,			0.70	,	-	1		
Registrar	DEC 2	9 1998	15	epera	19.	de	rack	2/							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ADA R. SUAREZ 12/23/98 12:06PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

If Under 1 Year | If Under 24 Hrs.

LAUREL

PRINCE GEORGES

Birthplace (State or Foreign Country)

HISPANIC

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 Yes XXNo

PUERTO RICO

**Funeral** Director

Physician

/Medical

ahow r than "natural", or Name 23s or 28sef ahor 4 deeth

72 hours after filed within 7 Hyglens. permit. Peges 1 and 2 should be filed wit Department of Heelth and Mental hygient Important: If hem 27 is marked other that eny lifury or other traumatic event, that panes.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

be executed

Box 68760.

P.O.

Records.

Division of Vital

physician end the buriel-transit 980

tal or Attending Physician: Tra effections to the conficulty at Director: After this certifical ed in by the funeral director, p Be 10 Certification: To the Hospital of within 24 hours of To the Funeral Completely filled pdical

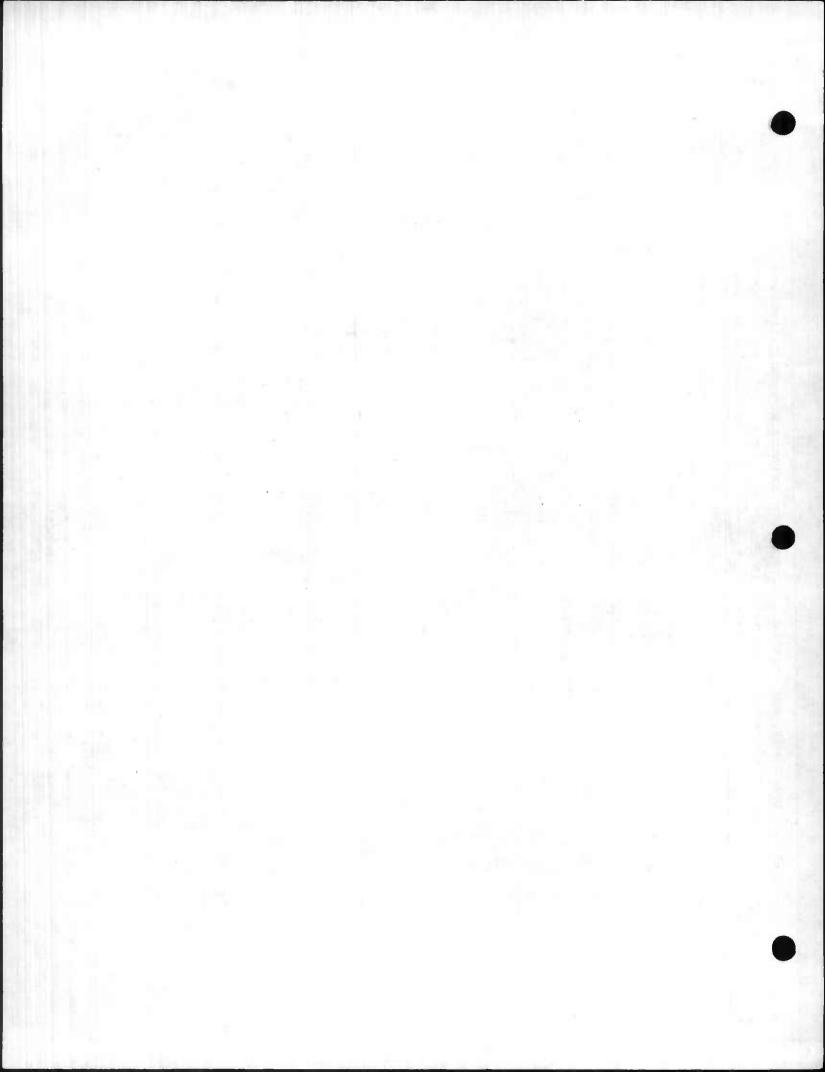
Examiner LAUREL REGIONAL HOSPITAL 5. Social Security Number 119-22-5721 Usuat Residence of Deceders 10a. State Director MD 10a Street and Number Funeral à Completed 12 Be 20a. Method of Disposition Kwat Immediate Cause (Finel disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ician/Medical Physi by Completed

8. Date of Birth (Month, Day, Year) Days 10 M 20 F Months Hours 71 MAY 16, 1927 10b. County 10c. City, Town or Location MONTGOMERY BURTONSVILLE 10f. Zio Code 10g, Citizen of What Country? 4312 REGALWOOD TERRACE 20866 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Yes 2 No Specify: Specify. 3Ki Widowed 4 □ Divorced PUERTO RICO 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) ISMAEL RODRIGUEZ MILAGROS CEBOLLERO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEELKA MEIN / DAUGHTER 4312 REGALWOOD TERRACE BURTONSVILLE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FORT LINCOLN CREMATORY 12/26/98 BRENTWOOD MARYLAND 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Licensee lery 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904 23a. Pert1. Enter the disea, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause or each line. MYDCARDIACINFARCTION CONGESTIVE FIFART 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 1 Yes 2 DNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 Homicide

7. Age (In yrs. last birthday)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28t. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 LOLUWOOD DRIVE SILVER BATRA RATHU m'O 32. Redistrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL** 

State Registrar



	State	of Marylar				lealth an	nd Me	ental Hy	/giene	3 4	1378			
1. Decedent's Neme (First, Midd	fla, Last)							2. Deta of De		Mana	3. Time of Death			
Bertie B. Swan	n							Month Decemb		1998				
4e Facility Name (If not institute	on, giva street end	number)			4	b. City, Town	n, or Loc	cation of Dea	th 4c. Cou	nty of Dee	ith			
4815 Boiling B	rook Par	kway				Rockv	ille	e	Mor	itgom	ery			
5. Social Security Number	6. Sex	7. Age (In yrs.	lest birthdey)	If Under Months	1 Yaar Deys	H Under 24 Hours	Hrs. Min.	8. Date of Bi (Month, D	rth ev. Year)	9. Bir	thplace (Steta or Foreign ountry)			
578-34-3073	1□ M 213 F	85	Yrs.	MONUN	Doys	110013	]	Nov. 2	6, 1913	A1	abama			
Usuel Residence of Decedent  10e. Stete 10b. Count		100 0	ity, Town or Lo	antion							10d. Inside City Limits			
Maryland Mont	gomery		ckville								1 ☐ Yes 2 ₺ No			
10e. Street and Number	manda Dani	1		10f. Zip		0.50			10g. Citizan					
4815 Boiling B		KWay ecedant Ever in U	10 101	Man Dann		852	-0 (0	aif . Van as 21	United		.Ces erican Indian,			
11. Maritai Status  1 □ Nevar Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed		f Yes, spe		ispanIc Orlgin n, Mexican, F Specify:	Puerto F	Rican, etc.)	Spec	leck, Whi					
(Specify only high				dent's Usua kind of wo	rk done d	during most of	of workin	og .	18b. Kind of	Business	/Industry			
Elementery/Secondary (0-12)	College	e (1-4or 5+)	Infor	mati	on S	pecial:	ist		Federa	al Go	vernment			
17. Fether's Neme (First, Middle	, Last)							(First, Middle	a, Meidan Sum	ema)				
John L. Bottom	ıs					Maude	v.	Chamb	ers					
19a. Informent's Neme/Reletion			19b. Mellin	ng Address	(Street	end Number o	or Rure	Route Numi	ber, City or Tov	vn, Stete,	Zip Code)			
Virginia M. Sw	ann/Daug					Brook E	Park				D 20852			
20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (-		om Stete	Plece of Dispo cemetery, cren rklawn	netory or c	otner plac		er 29	9, 1998			Town, State  Maryland			
21. Signature of Fune at Service 23e. Pert1. The direction of seese, c shock, or heert failure. Lis	or complications the	MO1 t caused the deen n each line.	126 Ro	ckvi.	lle,	Inc., Maryla	300 and	West 20850	Montgo -2805		Approximate Interval Between Onset and Death			
Immediate Cause (Finel disease or condition resulting in death)	. Met	astatic	Breast	Canc	er						3 Months			
rasoling in dadily		Due to (	or es a conseq	quence of):										
Sequentially list conditions, if eny, leeding to immediate	b. Ade	nocarcin Due to (	oma of								10 Years			
cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In death) Last	c	Due to (	or es a conseq	uence of):										
Part it. Other significant condit	ons contributing to	death but not re	sulting In the u	nderlying o	cause giv	en in Pert t.			tobacco uss		e to the causs of death? Probably 4 Unknown			
						şı.		24e. We	s en eutopsy formed?	24b.	Were autopsy findings available prior to completion of causa of deeth?			
								10	Yas 2 No		1 Yes 2 No			
25. Wes case referred to medica					Lou		of Deeth	(Check only	one)					
1 ☐ Yas 2 ☒ No			ER/Outpatier		Marine Street	4 LI NUISI			sidence 8 🗆		ecify)			
27. Menner of Deeth  1 🖾 Netural 5 🗆 Pend		ita of Injury Ionth, Dey Year)	28b. Time of Injury	M 2	28c. Injun Worl			28d. Describe	how injury oc	curred				
3 ☐ Sulcide 6 ☐ Could	not be 28e. Ple										d Number or Rural Route Number,			
	ng Physician: To I Examiner: On the end m													
29b. Signature and fittle of certif	or MM	0 11	^	29	c. Licens	e number			29d. Data sig	ned (Mor	oth, Day, Year)			

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician /Medical **Examiner** 

Funerat Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 Is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exponer must be notified at once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

31. Dete filed (Month, Day, Year)

DEC 28

G. Peter Pushkas, M.D. 32. Registrer's Signature

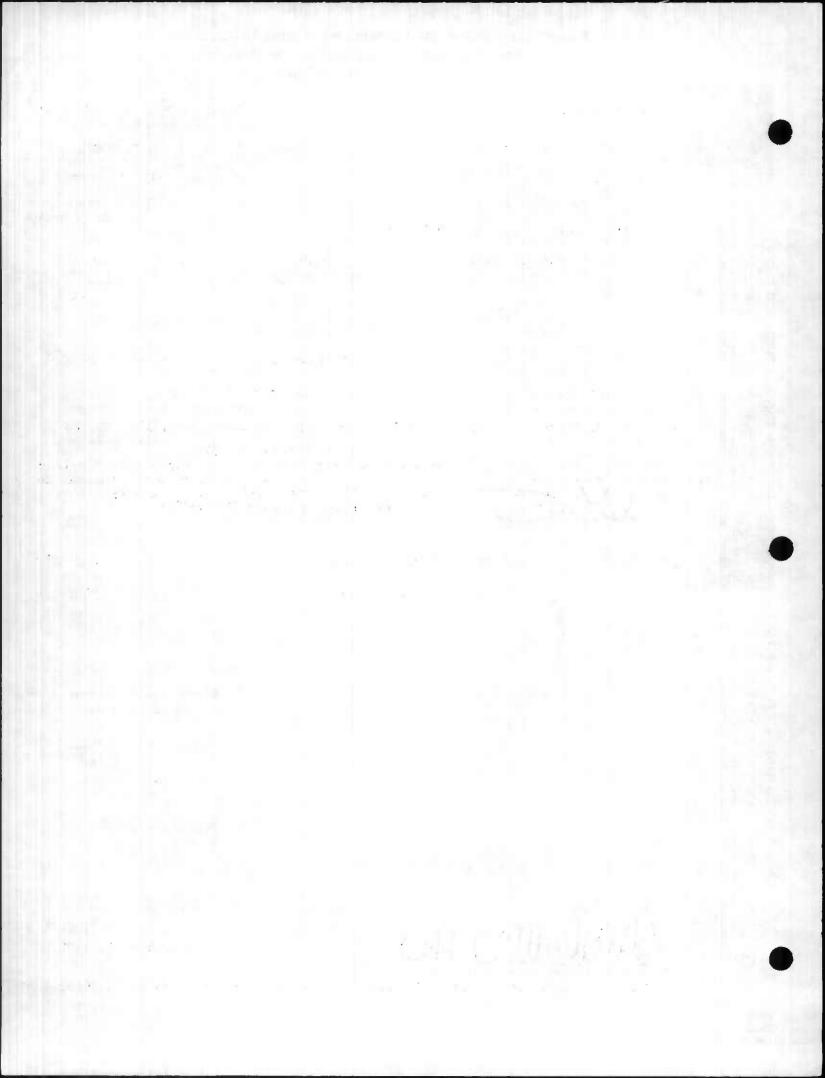
30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

11510 Old Georgetown Road, Rockville, Maryland 20852-2736

D21531

December 24, 1998

DHMH 16 Rsv 6/95



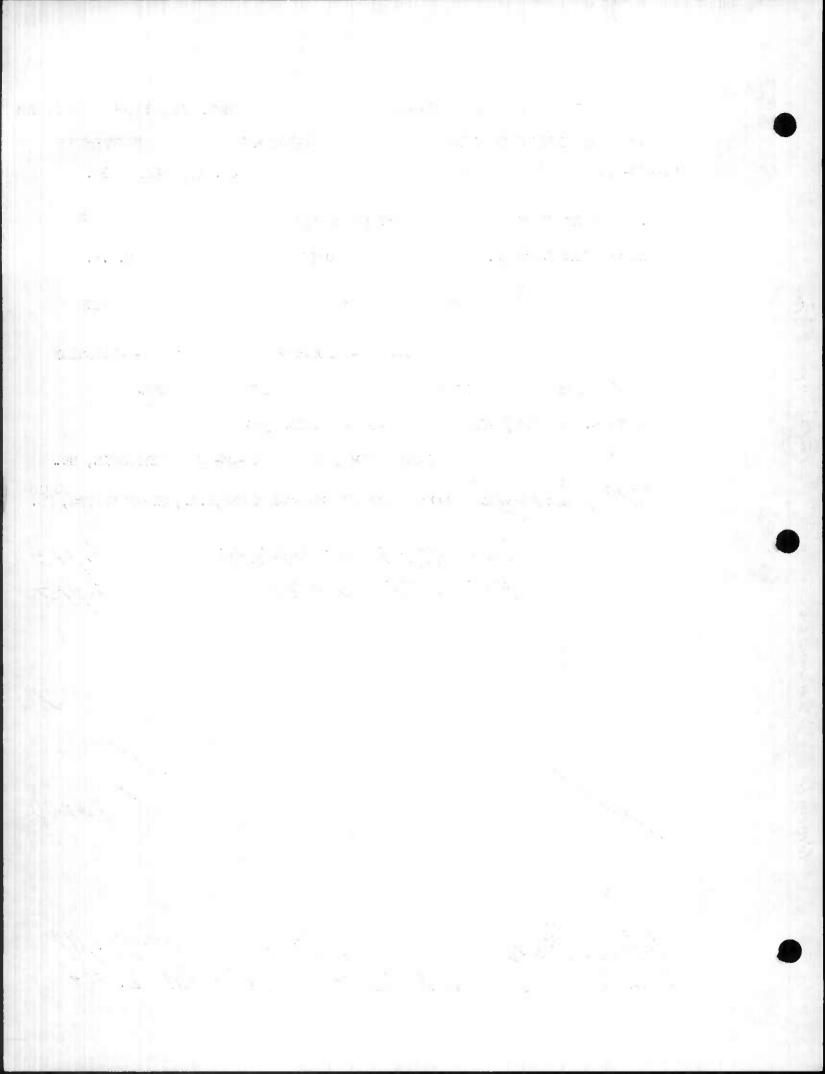
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month SZABADOS DEC. NICHOLAS J. 23, 1998 9:50 AM /Medicai 4e. Fecliity Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner JOSEPH RICHEY HOSPICE BALTIMORE BALTIMORE S. Dete of Birth (Month, Day, Year) OCT. 19, 1912 If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 9. Birthpiece (State or Foreign Country)
PA. 7. Age (In yrs. last birthday) **Funeral** 1**X**0 M 2□ F Months Days Yrs. 212-20-5749 86 Director Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Rem 27 is marked other than "natural", or Rems 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 10d, inside City Limits Director YNYes 2□No MD. MONTGOMERY NORTH BETHESDA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 11924 STONEWOOD LA. Funerai U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien, should be filed within 72 hours efter ond Mentel Hygiene.

merked other than "natural", or fee Biack, White, etc. 1 Never Married 20 Married Baltimore, Maryland 21215-0020 Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 5+ LAWYER - EDUCATOR LAW - EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 should be fi and Mentel I-NICHOLAS SZABADOS 2 IRMA permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ROSANNE D. SZABADOS/ WIFE SAME AS 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-28-98 CHAMBERS CREMATORY RIVERDALE. MD. 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility erall M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23e. Pert1. Enter the disease, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one sause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in death) Examiner Examiner buriei-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequenca of): physician a Box 68760 Physician/Medical Due to (or es e consequenca of): 80 950 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Onknown þ 24b. W autopsy findings eileble prior to completion of cause of death? 24e. Wes an autopsy performed? Completed peen : has page 2 1□Yes 2 100 certificate Division of Vital or Attanding Physician: 25. Wes case referred to nodical exeminer? Be 26. Place of Deeth | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specific 1 Yes Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Deeth 28d. Describe how injury occurred 28c. injury at Work? After 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No after death. investigetion 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as atated. (Check only one) 2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. within To the 29d. Dete signed (Month, Day, Yea. 29c. License number 0 2011 cause of deeth (item/23a) (Type, Print) 31. Dete filed (Month, D. State Registrar

**DHMH 16 Rav 6/95** 

52.464dos



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Dav Month Yaar Margaret Brooke Smith 28, 1998 10:24 pm Dec 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Baltimore New Port Assisted Living Reisterstown If Undar 24 Hrs. If Lindar 1 Yeer 8. Date of Birth (Month, Day, Year) Jun 3,1907 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foraign Country) Days Months Hours 1 M & F 91 Vre 215-16-1494 Maryland Usual Rasidance of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Reisterstown 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21 South Lake Way 21136 USA Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Datas: 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) U.S. Coast Guard Administration Assistant 18. Mother's Name (First, Middle, Melden Sumeme) 17 Father's Name (First, Middle, Last) Gertrude McClleand Charles F. Brooke 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Jane Hilliard, daughter 21 South Lake Way, Reisterstown, MD 21136 20b. Place of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 12/29 Carroll Cremations Hampstead, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Thrombois EREBYA L Ardrovascular Lieap > escloso s'o Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death? 1 Yes 2 DN6 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 20 No 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner

deeth certificate be executed

Box 68760

P.O.

Division of Vitai Records,

or Attending

Hospital

To the Hosp within 24 hos To the Fune completely fi

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Directo

Funeral

b

Completed

Be

the Meryland

death

filed within 72 hours after

Hygiene.

. Peges 1 end 2 should be file ment of Health and Mentel Hy lant: If frem 27 is marked oth jury or other traumatic even

Depertment If Important: If any Injury or

Baltimore, Maryland 21215-0020

Examine Physician/Medical by Completed Be To Certification:

physician end s the burial-trans 56 nse for ed by the a signed t should l certificate hes b irector, page 2 s this funeral After death. by the in 24 hour. the Funeral Direction 3

25. Was case referred to medical examiner? 1 Yes 27. Menne of Deeth

1 Netural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Pey Y

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 1@ Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

29d. Data signed (Month, Day, Year)

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ma DOCUL 0

31. Date filed (Month, Dey, Year) DEC 2 9 1998 32. Registrer's Signature

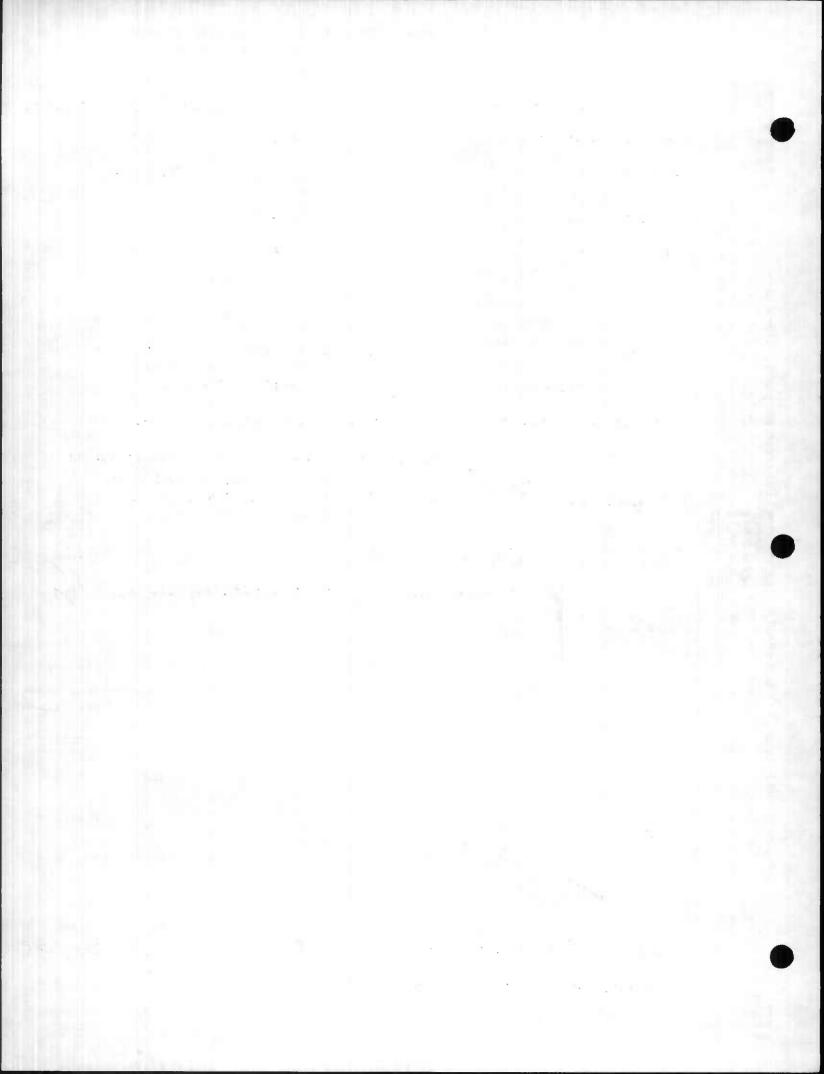
State Registrar

edicai

29a. Certifier

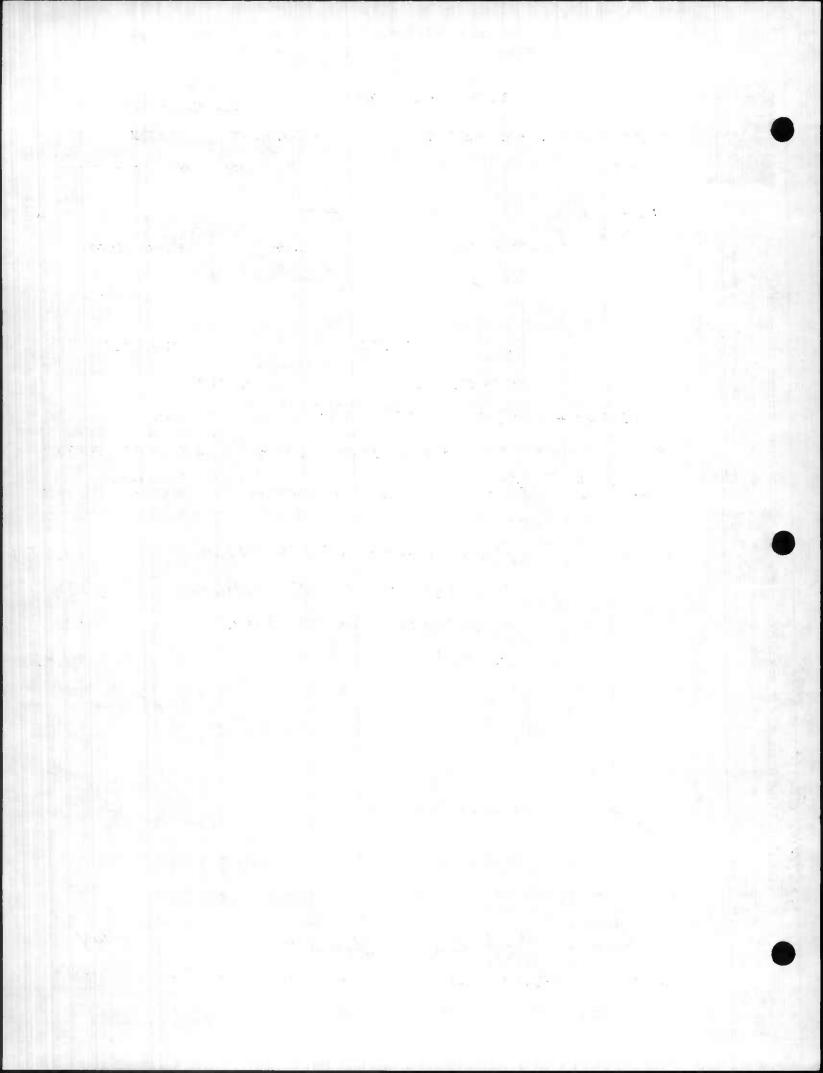
(Check only

29b. Signature and title of certified



State of Maryland / Department of Health and Mental Hygiene

				Certificate of	of Death		Reg. No.							
Physician	Decedant's Nama (First, Mid	die, Last) ELS	IE GRAY	SHANK		2. Date of Dec Month DECEMBE	Day	Year 998	3. Tima of Death					
/ /Medical Examiner	4a Facility Name (If not institute CARROLL COUN'				4b. City, Town, or to WESTMINS	ocation of Death		of Death	1.00					
Funeral Director	5. Social Security Number 220–36–8811	6. Sax 1 □ M 2 🔀 F	Aga (In yrs. last birt	thday) If Undar 1 Yo Months Da		8. Data of Birt Month, Day SEPT	(9, 1906	place (Stata or Foreign offic) YLAND						
h the Maryland r 28a-f show a notitied at	Usual Rasidance of Dacedant  10a. Stata 10b. Coun  MARYLAND CARR	*	10c. City, Town		WOOD			1	0d. Insida City Limits 1 ☐ Yas 2 🕅 No					
# ° M O	10e. Street and Number	981 WATSON	LANE	10f. Zip Coo	21764		10g. Citizen of V UNITED		*					
5 22 5	11. Marital Status 1 Navar Married 2 Ma 3 X Widowed 4 Divorce	If Vas Give	<b>⊠</b> No	13. Was Decedent If Yas, specify (	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yas or No- o Rican, atc.)	Blac	e - Amaric k, White, :: WHI						
within 72 ho ene. than "natur he wadcal	15. Decede (Spacify only high Elamantary/Secondary (0-12)	ant's Education ast grada completed)  Collega (1-4		Decedant's Usual Oc (Giva kind of work do lifa. DO NOT usa re TEACHER	ccupation na during most of wor tired)	of working 16b. Kind of Busin			dustry					
yland ould be file Mentel Hy marked othe atic avant.		17. Father's Nama (First, Middle, Last)  18. Mothar's Nama (First, Middle, Maiden Sumame)  JOHN PARKER GRAY  EFFIE HAISLIP												
, Mary end 2 sho selft end 1 127 la ma or traumo	19a. Informant's Name/Relation	nship <i>(Type Bro</i> THE NK / IN-LAW	R- 19b.		reet and Number or Ru STATION ROA		er, City or Town, EYTOWN,		21787					
Baltimore, Maryland 2 permit. Pages 1 end 2 should be filed Department of Heelth end Mentel Hygin Important: if flam 27 is marked other any injury or other traumatic avant, I price.  To Be Co	20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other		own, Stata MARYLAND											
Balt permit. Depart Importa any inje	21. Signature of Funeral Service	21. Signature of Funeral Service Licensee  22. Nama and Address of Facility  23. Nama and Address of Facility  24. Nama and Address of Facility  25. Nama and Address of Facility  26. SKILES FUNERAL HOME  136 E. BALTIMORE STREET  130 TANEYTOWN, MD. 21  23a. Pall. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.												
Physician /Medical Examiner  Examiner Examiner	fmmediata Causa (Final disaasa or condition rasulting In deeth)  Sequentially list conditions, if any, leeding to immediate cause. Entar undarlying Causa (Disaasa or Injury	a. VEA	VTRICU Dua to (or as a o	Consaquance of):  WE HE Consaquance of):	IBRILLA EART F	TION	/		Onsat and Death  MINUETE,  DAYS					
ox 6876( certificate be iding physicia ise as the bur	Causa (Disasas or Injury that initiated events rasulting in daath) Last	c. MYO CARDIAL INFARCTION Due to (or as a consequence of):  DAY  D.A.Y.												
P.O. Bo hat the death of d by the etten effeched for u	Part if. Other significant condi	tobacco use contributs to the cause of death?  Yas 2 No 3 Probably 4 Unknown												
cords, requires the been signed should be deleted by			24a. Was	24a. Was an sutopsy performed? 24b.		ere autopsy findings allable prior to impletion of cause death?								
Vital Record sician: The lew requir certificate has been s frector, page 2 should		101	163 23No		Yes 25-No									
Of Vita Physician: this certific ral director.	25. Was case referred to medic examiner?	Hospital:			Othor	ath (Check only o								
Division of or Attending Physitier deeth.  Shrector: After this in by the funeral distribution: To striffication: To	3 Suicida 6 Coul	28a. Date of (Month, tigation	Injury 28b. 7 Day Year) 1	Time of 28c.	Injury at Work?		now injury occur Street and Numb	red	ny) al Routa Number,					
DIVI To the Hospital or At within 24 hours affect on To the Funeral Direct completely filled in by Medical Certifi	29e. Cartifier 1 - Certify (Check only one) 2 Medica	ing Physician: To the base and manna	is of axamination an	, daath occurrad at th d/or invastigation, in r	e time, dete end place ny opinion, daath occu	o, and dua to tha irred at the time,	cause(s) end ma data and piace,	nner es a and due t	itated. o the cause(s)					
To the within 2 To the comple	29b. Signatura and titla of certif		'MD	29c. Lk	canse number		29d. Date signe	d (Month,	Day, Year)					
	30. Name and addrass of person	n who completed ceusa HALABI	of daath (Itam 23a)	(Type, Print) CCG-H		emorial inster,		d 21	157					
State Registrar	31. Date filed (Month, Day, Yea		gistrar's Signatura	B. A.	parks									



		1. Decedent's Name (First, Middle,			CE	ertificate	UI	Dealil		2. Dete of	Reg. No.		3. Time of Death		
Physic /Med		TIMOTHY JAM	ES SANN							Month DEC.		Year 198	0245 AM		
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Funera Directo		215-27-9798	3. Sex 1 <b>X</b> M 2 □ F	Aga (In yrs. la 25	st birthday Yrs.	Months	1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Dala of (Month, NOV -	Birth Day, Year) 3, 1973	9. Birthp Coun MARY	lace (State or Foreign try) TLAND		
land tand		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Location								11	Od. Inside City Limits		
Mary a-f sh	tor	MARYLAND TALB	TC	ST	. MIC	HAELS							1 X Yes 2 □ No		
or 28	Director	10e. Sireel and Number	6-05-6			10f. Zip					10g. Citizen of	Whal Coun	try?		
eath v		701 NEW LANE	12 Was Darada	ot Ever in II S	12		2166		inin? (Sn	acity Vas or	U.S.	ce - Americ	an Indian		
within 72 hours after death with the Maryland ene. than "natural", or hema 23e or 28e-f show in Marges! Examiner must be notified at	by Funeral	11. Meritel Stetus  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Armed Force	Wes Decedent Ever in U.S. Armed Forces?  1 X Yas 2 □ No If Yes, Give Year or Detes: 1992–93					n, Puerto	Rican, etc.)		ack, White,	etc.		
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s 1 and 2 should be filed with f Health and Mental Hygiene. tem 27 is marked other than other traumatic event, me 10	Be		17. Father's Name (First, Middle, Last)  18. Mother									me)			
should bud Menta	To	ALEX MICHAEL S.  19e. Informent's Neme/Reletionshi			19b. Mai	ling Address	(Street			E PUT	MAN mber, City or Town	n, State. Zin	Code)		
-		JANEL A. SANN/				BOX 1					ICHAELS, MARYLAND 21663				
	м	20e. Mathod of Disposition	□Damaval from Sta	0.00	nce of Disp	osition (Namemetory or of	ne of ther plea		- 1	Dete	20c. Location				
nit. Pagas artment of ortant: If its Injury or o		1 Buriel 2 X Cremelion 3 Removal from State 4 Donetion 5 Other (Specify)  CHESAPEAKE CREM. CTR.  12-24-98 CHESTER, MARYLAND  21. Signalure of Funeral Service Licensee													
permit. Pagas 1 a Department of Hea Important: If item any Injury or othe page.		21. Signature of Funeral Service Li	Mau D	CFS	P	FELLOW	vs,	HELFE	INBE 1		NEWNAM I				
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Physician /Medical		Immediate Cause (Final	1	4 It	. 1	1	,					1	Onset and Deeth		
Examiner	н	disease or condition resulting in deeth)	a	July Due to for	UL Y	Suyus	uls					i			
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cata be asscuted physician and the burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate	0.	Due to (or	es e conse	equence of):			l w				TELLIG		
siclan buria		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	c		The second				The same						
ificate physical as the	edicai	resulting In death) Last		Due to (or o	es a conse	quence of):						1			
death certific e attending p ed for use as	M/Ja		■ d									<u> </u>			
the att	Physician/M	Part II. Other significant condition	s contributing to death	but not resul	ting in the	underlying ca	ause giv	en in Pert	l.	23b. C	3b. Did tobacco use contribute to the cause of dea				
1 70 m										1	☐ Yes 2☐ No	3 Prof	bebly Unknow		
requires een sign hould be	Completed by									24a. W	Ves an autopsy erformed?	avi	ere autopsy findings ailable prior to mpletion of cause death?		
The law ate has b	omo										D <del>Yes</del> 2□No		Pries 2□ No		
	Be C	25. Was case referred to medical						26. Place	e of Deat	th (Check or	/				
ysic is ce	10	examiner? X⊠ Yes 2□ No	Hospital: 1 Inpa	atient 2 E	R/Outpatie	ent 3 DO	A Oth	er: 4 🗆 Ni	ursing Ho	oma 5 🗆 R	lesidence (XXX)	ther (Specif	AT SCENE		
Ing After	ion	27. Menner of Deeth  1 Netural 5 Pending		njury Day Year)	28b. Time Injury		Bc. Injur Wor	k?	Polo		r vehicle		ian		
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al or la safter	Certification:	4 ☐ Homicide determin	building,	etc. (Specify)	, ,,	5he	et			City or	Town, State)	ebe Ro	ral		
To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical		Physician: To the best aminer: On the basis and manner	of examination											
within 2 To the	Me	29b. Signature and little of certifier	000	e de la	0	29c.		e number			29d. Date sign	19, 1			
		30 Nama and addrass of person w	no completed cause of	f deeth (Item	Ø 23a) (Tvne	, Print)			-						
		Dennis J. C	hute mo	(nem)			tree	et, B	alti	more,	Maryland	2120	1		

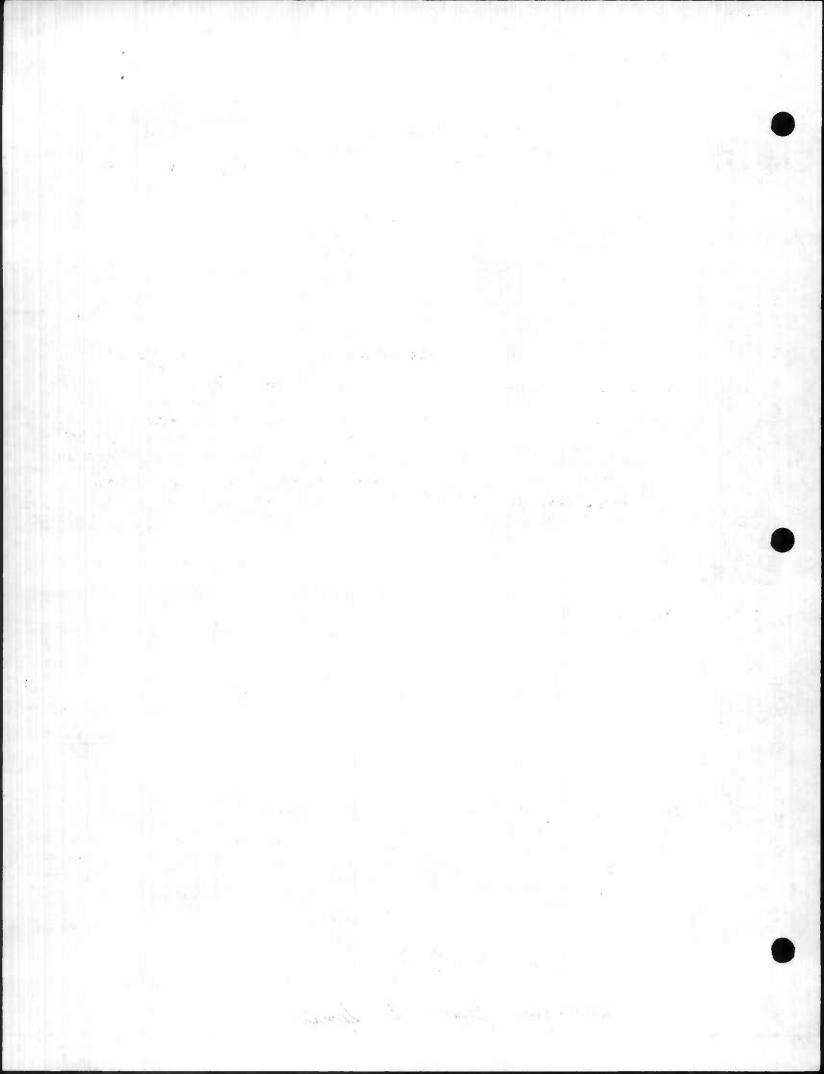
State Registrar

Dennis J. Chute M)

31. Dete filed (Month, Dey, Year)

DEC 28 1998

32. Registrar's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1 Decedent's Nama /First Middle Last Month **Physician** DOROTHY TRAVERS **DECEMBER 21, 1998** 5:51AM JOYCE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street end number) Examiner 2107 BUCKNELL TERRACE WHEATON, MONTGOMERY 7. Aga (In yrs. lest birthdey) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dev. Year) 9. Birthplaca (Steta or Foreign **Funeral** Months Days Hours Min 1 M 201 F Yrs. AUG. 16, 1908 MASSACHUSETTS Director 012-01-4690 Usual Rasidance of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ? is marked other than "natural", or items 23a or 28a-f show trsummitte event, the Medical Examiner maint be notified at 1 Yas 2 No Directo MD MONTGOMERY WHEATON 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? USA 20902 pemit. Pages 1 and 2 should be filed within 72 hours effer death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a and injury or other traumatic event, the Medical Examiner must once. 2107 BUCKNELL TERRACE Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - American Indian Black, White, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT HEALTH CARE 12 18. Mothar's Nama (First, Middle, Malden Surname) 17. Fathar's Nama (First, Middle, Last) MARY VENO EDWARD JOYCE 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Ralationship (Type, Print) 2107 BUCKNELL TERRACE SILVER SPRING, MD 20902 WALTER TRAVERS (SON) 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CREMATORY 12-23-98 BRENTWOOD, MD 22 Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE 21. Signer e of Fun - I Service Licensee AVENUE SILVER SRPING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** CONGESTIVE HEART FAILURE Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consaquance of): ATTORUSCUETATIC CHARDIOUNGCULAR OUTTO Examine physician and the burial-transit that the death certificete be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consaquance of) BIASETS) MELLITUK Box 68760 Physician/Medical Dua to (or as a consequence of): 98 attending esn ŏ 23b. Did tobacco use contribute to the causs of deeth? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown Records, P. þ The law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen s completion of cause of death? page 2 has 1 Yes 2 No certificete! Division of Vital Physician: 25. Was case referred to medical examiner? 15 Yes 2 □ No director Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Nasidance 6 Othar (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of Certification: 28c. Injury at After 1 Natural 2 Accidant Attending 5 Pending 1 Yes 2 No deeth. invastigation after deeth Director: 6 Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida within 24 hours after To the Funeral Direcompletely filled in b 9 Hospital 29a. Certilier (Check o edical

State Registra

29b. Sign

31. Data filed (Month, Dey, Year) DEC 29 1998

and title of certifier

32. Registrar's Signatura

OME

Nama and address of person who completed cause of death (Item 23a) (Type, Print) 11/25 POCKVILLE PIKE, LOCKVILLE, MO 20852

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

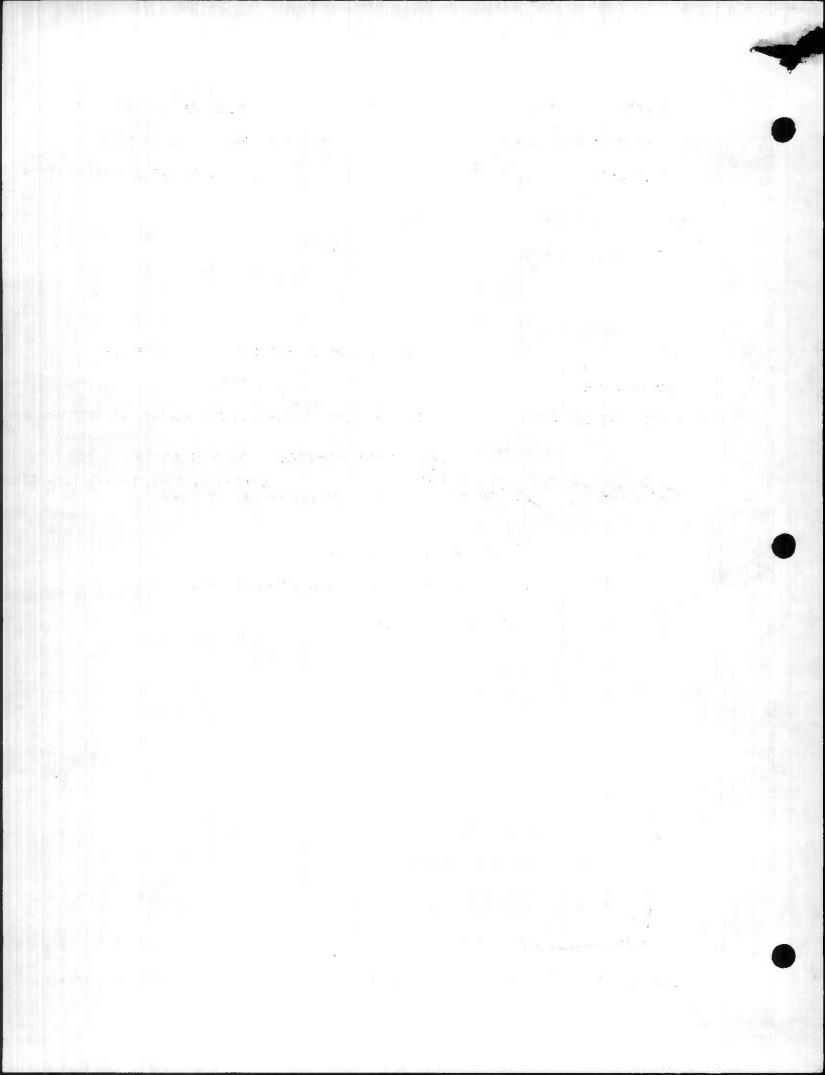
29c. License number

015236

29d. Date signed (Month, Day, Year)

DECOMBER 22, 1998

2



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Dav Vaar Audrey Sapp Tate December 18,1998 3:09 PM 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 20 F Days 225-42-4309 76 June 26, 1922 Virginia Usual Rasidance of Decedant 10a Stata 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Virginia N/A Norfolk 10e, Street and Number 10f. Zip Code 10g. Citizan of What Country? 2700 Virginia Beach Boulevard 23504 United States 12. Waa Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yas, Giva Yaar or Dataa: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puarto Rican, etc.) t4. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married 1 Yas 2 No Specify Specify: 3 □ Widowed 4 ☒ Divorced Black 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) 5+ Elamantary/Secondary (0-12) Teacher Public Schools 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Father's Nama (First, Middle, Last) James Lee Sapp Leola D. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey J. Childs, niece 1624 Webster St. N.W., Washington, D.C. 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burlai 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/98 Norfolk, Virginia Calvary Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 21. Signature of Funeral Service Licensee 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fallure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Cause (Final 8 days disaase or condition resulting in death) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Yaa 2 No 3 Probably 4 Unknown 24a, Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 XXVo 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show must be notified at

6 Norma 23a

"natural", or

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if item 27 is marked other than eny injury or other treumstrand.

72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital Attending Physician:

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Directo

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Completed

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Examiner physician and the burial-transit Physician/Medical à Completed page 2 Be Certification: To this After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun.

Part II. Other-significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartiflai (Check only one) 29b. Signatura and itla of certitian 29c. License number 29d. Data signed (Month, Day, Year)

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6130 LANDOVER RD COLEVER

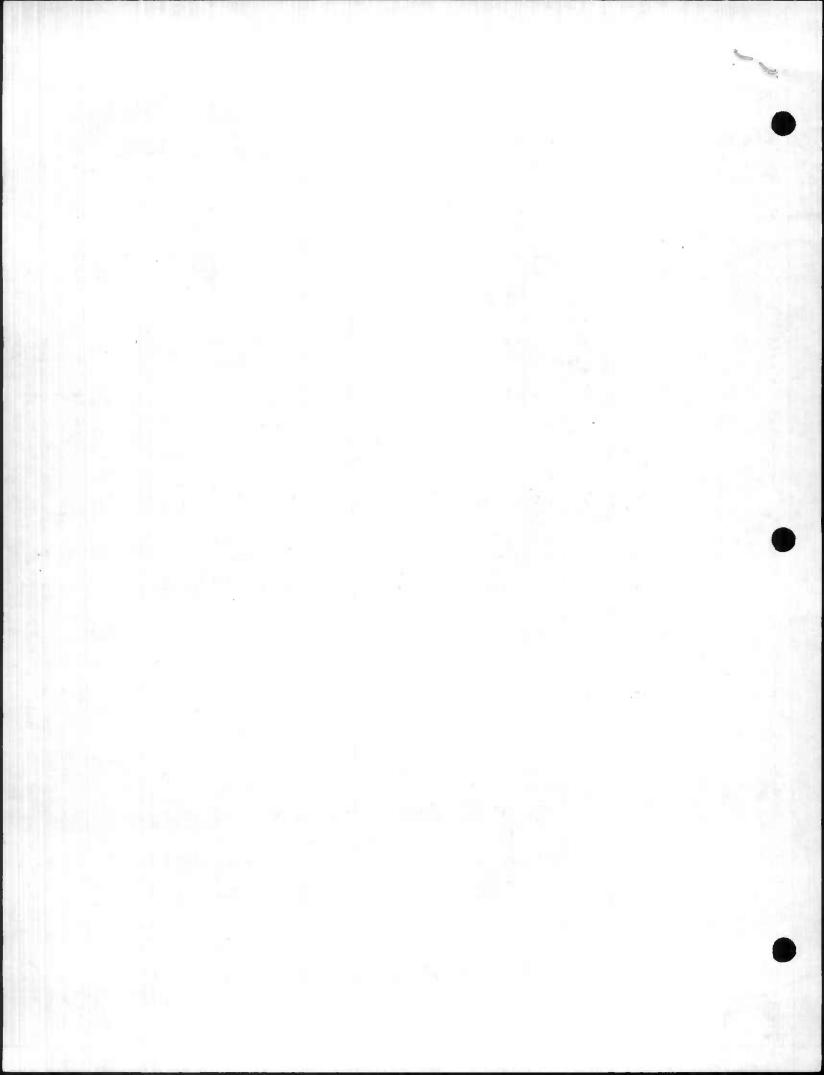
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31. Data tiled (Month, Day, Year)

um

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

Tity MO 32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Tima of Death Dey Month RUTH H. DECEMBER 27, 1998 7:10PM TALIAFERRO 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 15308 BASSWOOD COURT ROCKVILLE MONTGOMERY If Under 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthday) Days 1□M 2XF Months Hours Min 88 Yrs. JAN. 27, 1910 MARYLAND Usuei Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MONTGOMERY ROCKVILLE 10f. Zip Code 10g. Citizen of What Country? 15308 BASSWOOD COURT UNITED STATES 20853 12. Was Dacedant Ever In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 14. Rece - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Datas: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yas 2 No Specify: 3KD Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) INSURANCE INSURANCE ADJUSTER 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) EMMA (UNKNOWN) JOHN HAMMOND 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) 11469 COLUMBIA PIKE APT. C2 SILVER SPRING, MD20904 CAROLYN BLAUVELT 20b. Pieca of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 NBuriel 2 Cremation 3 Removel from State 12/31/98 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 22. Nama and Address of Fecility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD20904 Approximata Intarval Batween Onset end Death ATHEOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequance of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes ZE No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. injury at Work? 5 Pending 1 ☐ Yas 2 ☐ No Investigation 6 Could not be detarmined 28a. Placa of injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

**Examiner** O. Box 68760, Records, Division of Vitai

physician end is the burial-transit The lew requires that the death certificate be executed 88 ettending 980 ed by the e signed t peen is certificate has director, page 2 page 2 Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical etely filled in by the funeral director. pletely within 2 To the F

**Physician** 

/Medical

Examiner

579-16-6360

10a Stata

MARYLAND

11. Marital Status

10e. Street and Numbe

Immediata Causa (Final diseasa or condition resulting in death)

1 Yas 2 No

27. Manner of Death

2 Accident

3 Sulcida

29a. Certifiar

4 Homicide

(Check only one)

CHARLES M.

29b. Signatura and little of certific

1 XNatural

**Funeral** 

Director

or than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exemples. DOGS.

**Physician** 

/Medicai

Examiner

Physician/Medical

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Certification: To

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Registrar

Baitimore, Maryland 21215-0020

Directo

Funeral

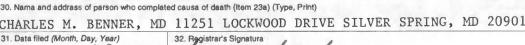
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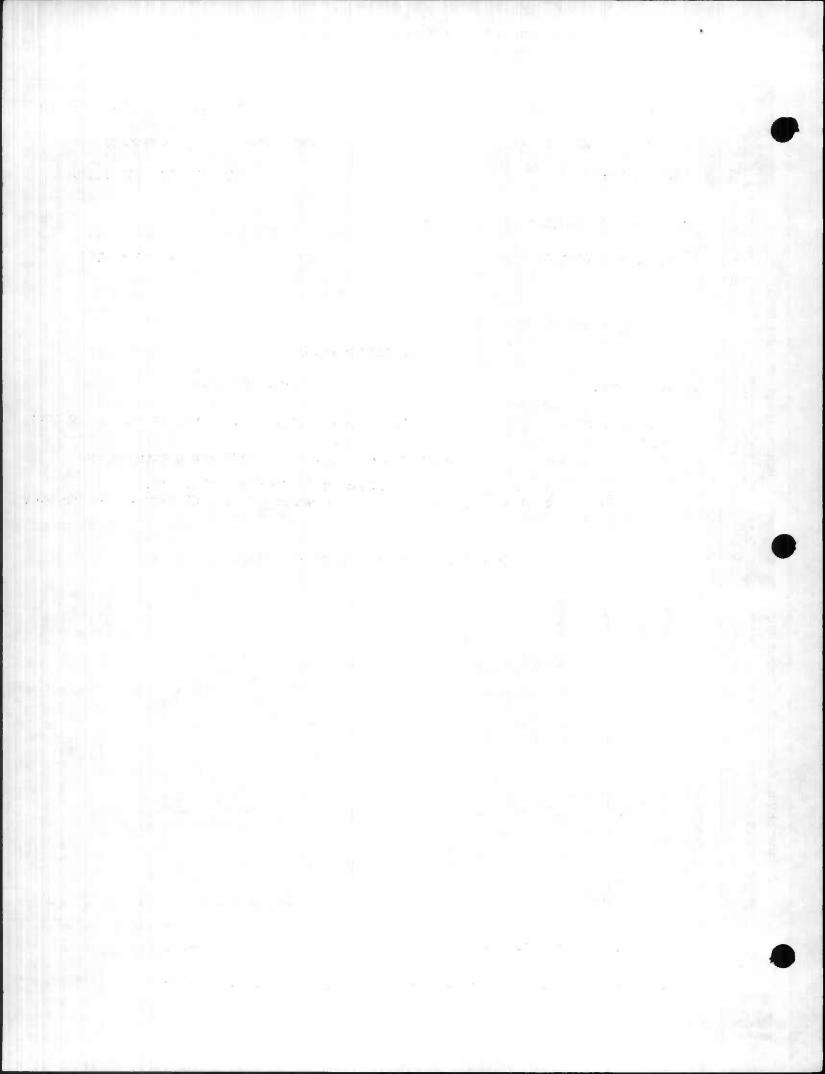
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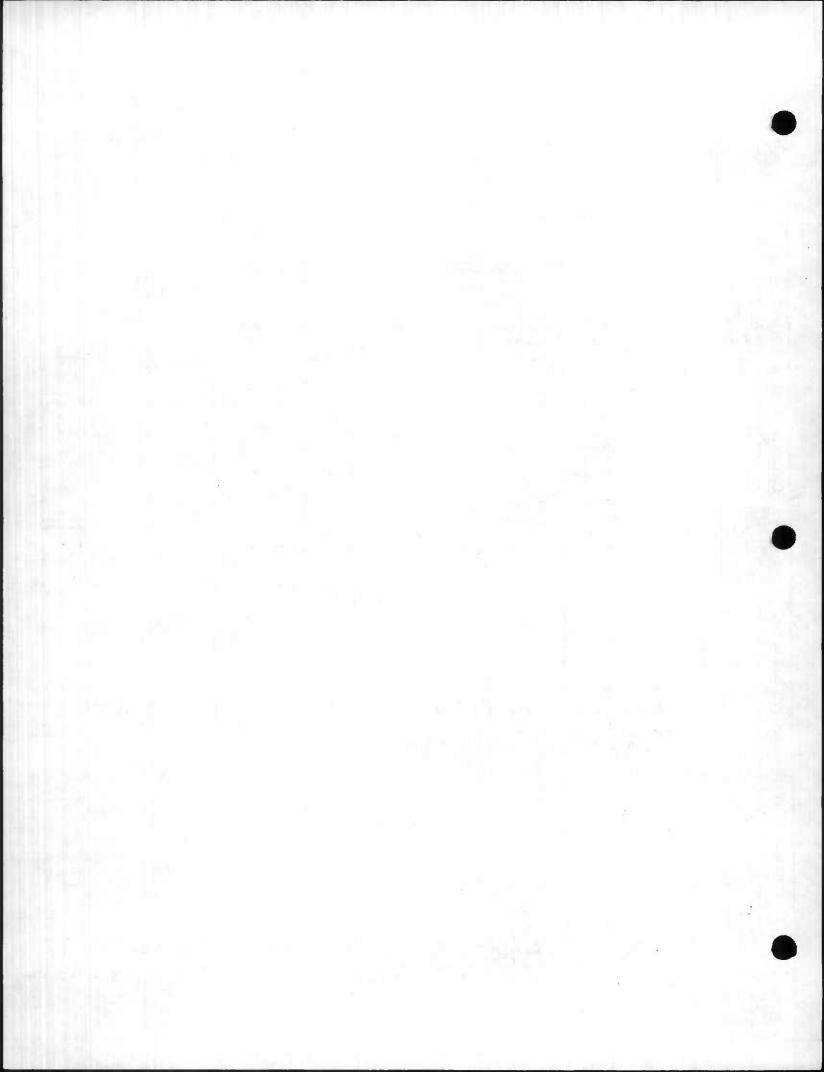
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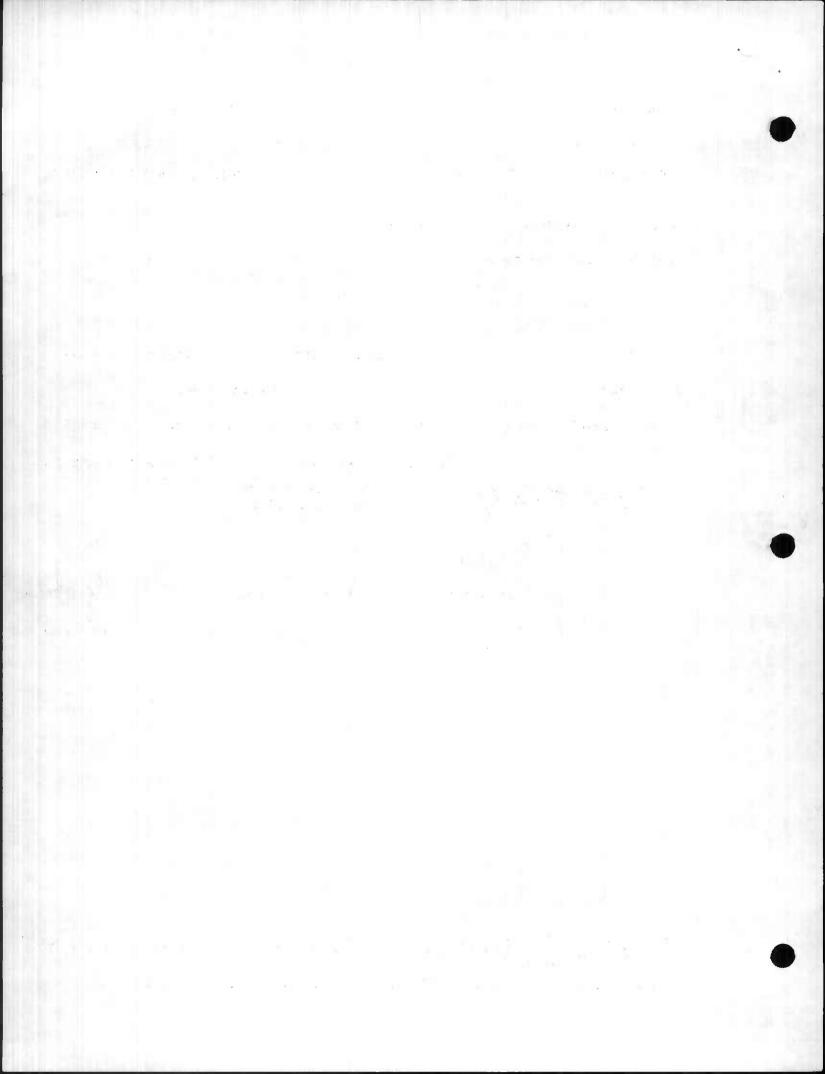


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 104107 220 AM (2. 1-015 DEC /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Columbia Howard County Oxeneral Ho ward If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 25 F 577-40-4310 75 May 1, Virginia Director Usual Residence of Decedent 10c. City, Town or Location or 28a-f show 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 XNo Director Montgomery Rockville 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with and Mentel Hygione.
and if flow 27 Is marked other than "natural", or frems 23e or lary or other thau marked other than "natural". r than "natural", or hams 23a or the Medical Examiner must be 4105 Southend Road 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Roy William Good Anna Mary Smucker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) H.L. Taylor 4105 Southend Road, Rockville, MD 20853 (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1/2798 pemit. Peges
Department of
Important: If It
any injury or o 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timberville Church of the Brethren Timberville, Virginia 22. Neme and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21 Signature of Funeral Service Licenses 20901 Silver Spring, MD Courte 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Physician/Medical Examiner ANTENY Disease Coronari physician and the burief-traneit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Due to (or as a consequence of) for use signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Respiratory Failure 3 Probably 4 Unknown 1 Yas 2 No Division of Vital Records. ğ Congretive Heart Failure 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Medical Certification: 1 Natural
2 Accident or Attending 5 Pending investigation s efter deeth. Il Director: Aft ed in by the fu 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 2 4 Homicide filled in To the Hospital within 24 hours a To the Funeral Completely filled (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier . Show MD D0052940 DEC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANTAY P. SHAH, WD 10605 Kicko Rd #210 Coulombia, MD 21044 MD 10805 Hickory & 31. Data filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95



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1	/Medical Examiner	4e Fecility Neme (If r	not institution, give	street end num	Terse			4b. City, Town, o	r Location of Deet		y of Deeth			
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1	Funeral	5. Sociel Security Nur	mber 6. Se	ex 7	7. Age (In yrs.	lest birthday)	If Under 1 Ye	er If Under 24 H	s. 8. Dete of Bir		Birthplece (State or Foreign Country)			
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5-0020	hours after death varial; or items 23s			12. Wes Deced Armed Ford 1 Tes 2 If Yes, Give Yeer or De	2][] No		Yes, specify C	of Hispenic Origin? Suben, Mexicen, Pue No Specify:	into Ricen, etc.)	Speci	eck, White, etc.			
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bu	T T T T T	17. Father's Neme (F	irst, Middle, Last)					18. Mother's N	eme (First, Middle	, Maiden Suma	me)			
la	Menta Menta		na					Fra	inces Sub	adolc				
Maryland	s me	19e. Informent's Nan	ne/Reletionship (7	ype, Print)		19b <sub>8</sub> Mailin	Address (Str	ngsworth	Byral Floute Numb	er, City or Town	n, State, Zip Code)			
	and alth	Richard Te	erselic	(Son)		1843	Holling	eworth Di			MD 20855			
Baltimore,	of Head	20e. Method of Dispo			20b. F	Plece of Dispos	sition (Name of netory or other	plece)	Dete	20c. Location	- City or Town, Stete			
E	Page ent of ry or		Cremetion 3 ☐ Other (Specify		late				12/29/98	Rockvi	lle, Maryland			
alti	Departmer Departmer Important any Injury phos.	21. Signeture of Fune	erel Service Licen:	see	2	22	Name end Ad	dress of Fecility I	eVol Fur	eral Ho	ome			
m	Dep de la constant de	170:	A 210	10.1/2	1	110	East 1	Deer Park	Drive					
		23e, Pert1, Enter the	disease, or comp	lications that da	used the deat	h. Do not ente	ithers	burg, MD	208 / / ac or respiretory e	errest.	Approximete			
	Dhysiolen	23e. Pert1. Enter the shock, or heart		Approximete Interval Between Onset end Deeth										
7	Physician //Medical	Immediete Ceusa (Fi												
1	Examiner	disease or condition resulting in deeth)		Day										
	<u> </u>			~ (	Due to (o	or es e consad	uende of):				( ) 11			
	nsit nIn			o ler	euro	W	HEV	romo	R		6 month			
	be executed ician and burial-transit	Sequentially list cond if eny, leeding to imm	ditions, nediete		Due to (	r es'e conseq	uence of):	0			1/2 0			
68760	physician s the buria	Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) leet												
387	physicia s the bur	resulting in deeth) Le	st			1								
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Box	death cert e attendin d for use													
o.	bed bed	Pert II. Other signific	ent conditions co	entributing to dee	23b, Did	23b. Did tobecco use contribute to the ceuse of death								
P.0	The law requires that the death centrale has been signed by the attending page 2 should be detached for use Completed by Physician/M								1 🗆	Yes 2 No	3 Probably 4 Unknow			
Records,	w requires that is been signed is should be det								Oto Was	/	24b. Were autopsy findings			
0	requires								perf	en autopsy ormed?	available prior to completion of cause			
ec	has b	-							000		of death?			
F	The Late has page								10	Yes 2XNo	1 Yes 2 No			
Vital	ysician: The is certificate director, pag	25. Was case referre examiner?	-						eath (Check only	one)				
of	Physician: this certific ral director,	1 ☐ Yes 2 ☐XN	0	Hospital: 1 ☐ In	patient 2	ER/Outpatien	3LI DOA		Home 5 ☐ Ras	idance 6 🗆 O	ther (Specify)			
n	After the funera		5 Pending	28e. Dete of (Month)	f Injury n, Dey Year)	28b. Time of Injury	28c. l	njury at Work?	28d. Describe	how injury occu	ırred			
Division	Attending r death. ector: After fune by the fune	2 Accident	Investigation				M 1	! ☐ Yes 2 ☐ No						
5	rect direct	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	209. FI909 (	of Injury - At he	ome, ferm, stre	et, fectory, offi	ce	28f. Location (	(Street end Nun wn, Stete)	nber or Rurel Route Number,			
	DIVISION ( toapital or Attending P thours after death. 'unerat Director: Aftert ely filled in by the funer (cal Certification:													
Ö		29a. Certifier 11\(\overline{\infty}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
Ō	24 hours of Funeral letely filled	29a. Certifier 1 (Check only 2 one)	☐ Medical Exam											
Ō	o the Hospital ithin 24 hours of the Funeral ompletely filled Medical C	29a. Certifier 1 (Check only 2 one)	☐ Medical Exam	and manne			29c. Lic	ense number		29d. Date sign	ed (Month, Day, Year)			
ia	To the Hospi within 24 hours To the Fune completely fil	29a. Certifier 1 (Check only 2 one)	☐ Medical Exam	and manne	10	Cm S				-				
ia	To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 (Check only one)  29b. Signature and tit	Medical Exam	DKI	elop	Cud	D	al392		-	ed (Month, Day, Year) CANDA 24, 1998			
ia	To the Hospi within 24 hours To the Fune completely fil	29a. Certifier 1 (Check only one) 29b. Signature and tit	Medical Exam	completed cause	/ /		Print)	21392		Dece	ender 24, 1998			
ia	To the Hospi within 24 hours To the Fune completely fil	29a. Certifier 1 (Check only one)  29b. Signature and tit	Medical Example of certifier as of person who continued to the continue of the	completed ceuse	/ /	Veirs	Print)	oad, Rock	cville, M	Dece				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

**Physician** /Medical Examiner

**Funeral** Director

with the Marylence 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at death filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be flied wit Department of Health and Mental Hygiens Important: If item 27 is merked other tha eny injury or other traumatic event, that once. pro

**Physician** /Medical Examiner

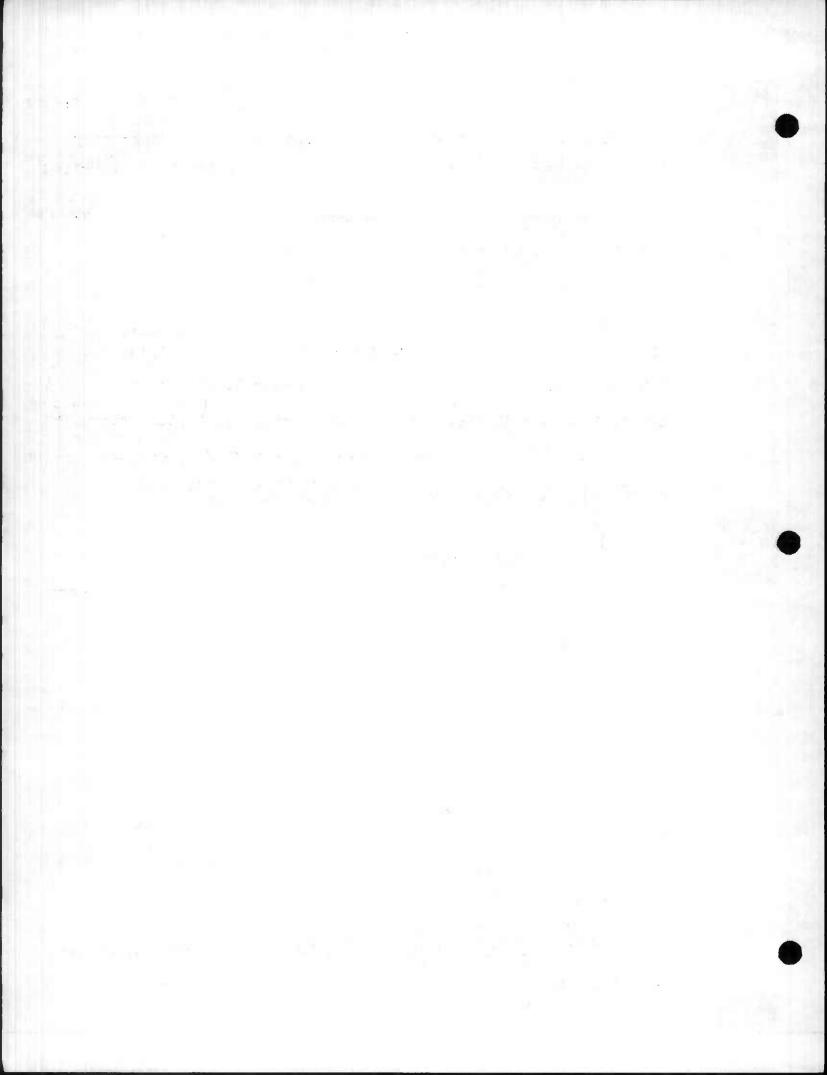
siclan end burial-transit physician the attending p the t signed by the been si has certificate this

certificate be executed P.O. Box 68760, Records, Division of Vital funeral director, After To the Hospital or Attending within 24 hours effect death. To the Funeral Director: Afte completely filled in by the funs

1. Decedant'a Nama (First, Middla, Last) 2. Data of Death 3 Time of Death DEC. 22, 1998 FRANKLIN CLAY THOMPSON 8:50 AM 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgome ry Hours Min. 8. Data of Birth (Month, Day, Year) 1963 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthpiaca (State or Foreign Country) Maryland 6. Sax Months Days M 20 F 220-74-7893 35 Yrs. Usual Rasidance of Decedant 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits Mas 2□No Director MD Gaithersburg Montgomery 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? 8333 Shady Spring Drive 20877 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married If Yas, Giva Yaar or Datas 1 ☐ Yas 2 No Specify: Specify: Black by 3 □ Widowad 4 □ Divorced Completed 15. Dacedant's Education (Spacify only highast grede completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Rockville Elamantary/Sacondary (0-12) Coilega (1-4or 5+) Mail Sorter Mailing Co. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Sumama) Wilbert Thompson Betty A. Stevenson 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) 20877 19a. Informant's Name/Relationship (Type, Print) Betty A. Thompson (Mother) 8333 Shady Spring Dr., Gaithersburg, 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Emory Grove Cemeteryl2/28/98 4 ☐ Donation 5 ☐ Other (Specify) Gaithersburg, MD 22. Nama and Addrass of Facility
SNOWDEN FUNERAL HOME, 21. Signatura 7 Funaral Sarvice Licensed 20850 ROCKVILLE, MD 23a. Part1. Enter the disassa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate tntarval Between Onset and Death Immadiata Causa (Final disaasa or condition rasulting in daath) minutes Respiratory Failure Dua to (or as a consequence of) Examiner AIDS Years Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Cause (Disaase or injury that initieted evants resulting in daath) Last Dua to (or es a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant → PROutpatient 3 ☐ DOA To 1 Yes 2 X No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 27. Mannar of Death Certification: 28b. Tima of Injury 28a. Data of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a, Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and place, end due to the cause(s) end menner as stated. 2 Madtcat Examtner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certified 29c. Licansa number 29d. Data signed (Month, Day, Year) December 22, 1998 30. Nama and address of person who completed causa of death (Item 22a) (Type, Print) Dr. William Dooley Wedical Center Rr. Rockville, mb 20850 9901 31. Data filed (Month, Day, Year) DEC 28

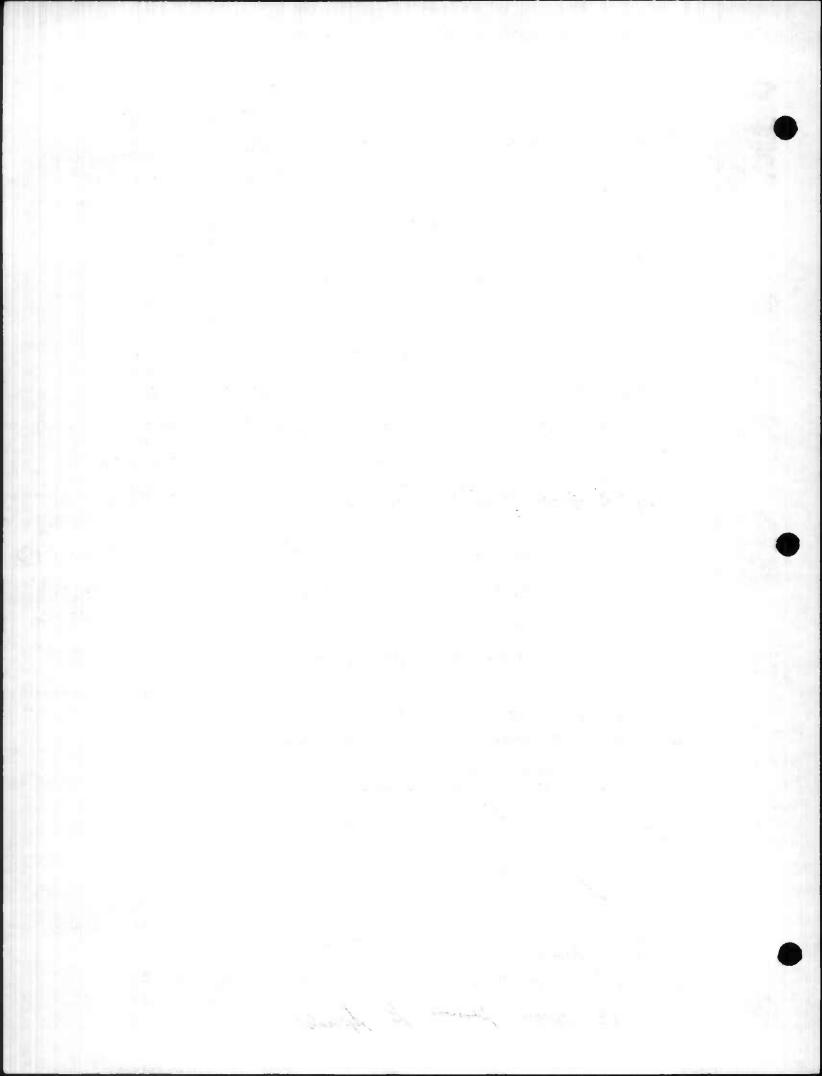
32. Registrer's Signetura

State Registrar



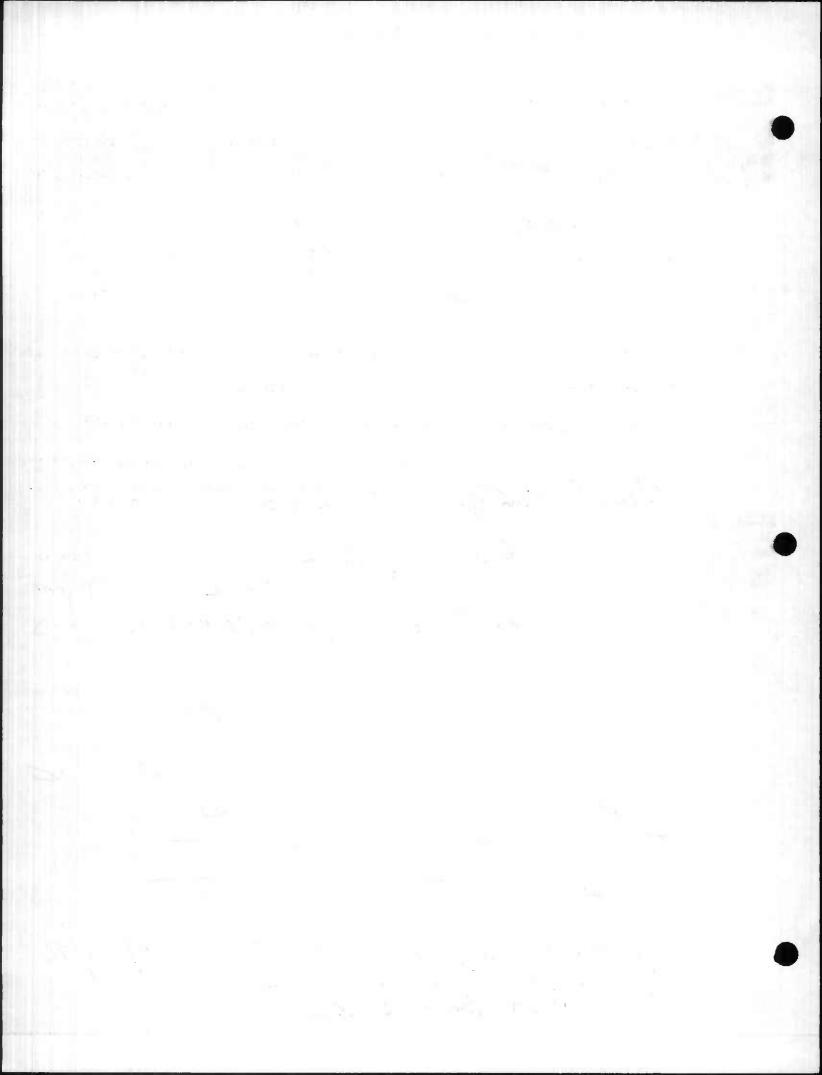
# Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1. Decedent's Neme (First, Mid	Irlia I asti			001	tificate of	Dealli	2. Date of Dec	Reg. No.		. Time of Death		
	Physic	ian								Month	Day	Year			
	/Medi		John			Walte	3r	Thom	oson	Decembe		990	712		
	Examir	ner	The Vent and Overs Break that I I I												
			5. Social Security Number	Queen	Anne's	_		Inc.	Cheste			nt			
ı	Funeral Director		217-03-9091	6. Sex.	2□ F 7. Ag	a (in yrs. 8:	lest birthday)  Yrs.	Months Days			1915	9. Birthplace Country) Maryla	(Stete or Foreig		
	enyland ehow	_	Usuel Residence of Decedent  10a. State 10b. Coun	ty		10c. Cit	y, Town or Loc	ation					inside City Limits		
	M Page	Director	Maryland Kent			Cl	nestert	own					NATES 2LING		
	के दे	Dire	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Country?			
	23a		408 Morgnec Roa	ad Apt	303			21620			USA				
0700-01717	72 hours after death with the Meryland "naturel", or items 23s or 28s-f show offest Evanther must be modified at	by Funeral	11. Marital Status  1 □ Nevar Married 2☒ Married 3 □ Widowed 4 □ Divorce	arried 1	Ves Decedent Armed Forces? ☐ Yas 201 f Yes, Give Yeer or Datas:	Evar In U. No		/as Decedant of Yes, specify Cul		(Specify Yas or No- erto Ricen, atc.)	14. Rad Bla Specif	ce - American II ck, Whita, atc. y: Whit			
ה ה	hin 72 ho	Completed	15. Decede (Specify only high	ent's Educetio	n mplotodi		18a. Deced	ent's Usuel Occu	petion	undring.	16b. Kind of B	of Business/Industry			
7	5 -3	pie	Elamantery/Secondery (0-12	-	College (1-4or 5	5+)	life. D	O NOT use retir	during most of weed)	roiking					
		LOC	11				Truc	k Drive	r		Oil Ir	ndustry			
mai yiaiid		Be (	17. Fether's Neme (First, Middle	e, Last)					18. Mother's N	leme (First, Middle,	Meiden Surnar	ne)			
0	should be ind Mental marked c	To	John Merritt Th	nompsor	1				Mary Ca	roline Ha	ddaway				
5	d 2 sho th and i 7 is me traums		19a. Informant's Name/Relation	r, City or Town	Stete, Zip Coo	ie)									
	ロモトは		Katherine A. Th	nompsor	n/Wife		408 Mo	rgnec R	oad, Apt	#303, Ch	esterto	own, MD	21620		
5	es 1 an of Heali f Item 2 r other		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. L								20c. Location				
	Peges ient of nt: If It iry or o		142-Borial 2 Cremation 3 Chemoval from State									artown	MD		
	permit. Peges Department of I important: If Ite any injury or o		21. Signeture of Funaral Service Licensee 22. Nama and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.												
	40 T + 0		Fick of	1. 9/1	yent	سنعا						21620	e, I.A.		
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.												
	Physician /Medicai Examiner		tmmediete Cause (Finel disaase or condition		TA COIA	C A	SYSTOI	ic An	RUST			Ons	erval Between set and Death		
		Jer	resulting in deeth)			Due to (o	r es a consequ					1	nurs		
	d d ansit	Examiner	Cognecticity list conditions	b			r es e consequ	-	7.5			1			
5	ificete be executed g physician and as the buriel-transit		Sequentially IIst conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury	ر ا	PRUTE							170	ours		
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DIVISION OF WIRE MCCOLUS,	Ine law requires that the death cer ate hes been signed by the attendir page 2 should be deteched for use	Completed by	REMODERNO						PARIN	24a. Wes o		availab	utopsy findings ia prior to tion of causa h?		
			SUPERIOR ME	SCHEN	nic m	TIM)	BOW	10515	_		as 2 No	1 □ Ye	s 2 No		
	certi	Be	25. Wes case raferred to medic exeminer?	Hospi	tal:			0		eeth Check on o					
	Physicien: r this certific ral director.	. To	1 ☐ Yes 2 ☑ No 27. Menner of Death	26			ER/Outpatient 28b. Time of	3∐ DOA	4 ☐ Nursing	Home 5 ☐ Rasid					
	aath. or: After he fune	ation	1 Neturei 5 Pend 2 Accident Invas	tigation	Be. Dete of Inju (Month, Da)	Year)	Injury	28c. Inju Wo M 1	rk? ]Yes 2□No	28d. Describe N	ow injury occur	red			
	to the hospital or Attending Privile 10 the hours after death.  To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Piece of tnjury - At home, ferm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	24 hou	edicai	29e. Certifiar 1 Certify (Check only one)	I Examiner: (	n: To the best of On the basis of and mennar sta	exeminat	wiedge, death ion and/or Inve	occurred et the t estigetion, in my	ime, dete end ple opinion, deeth oc	ca, end due to the c curred et the time, c	euse(s) end mo leta and pieca,	enner es steted end due to the	l. cause(s)		
	ithin of the	Me	29b. Signature and title of certif					29c. Lican	se number		29d. Dete signe	d (Month, Dav.	Year)		
	- 3 ⊨ ర		Faul R.		mn										
ľ			Jaul Johnson MD  D052487  12/11/98  30. Name end eddress oberson who completed cause of deeth (item 23e) (Type, Print)												
			30. Name and address of person	n who comple			23e) (Type, P	rint)	TOWN		1620				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	Decedent's Nama (First, Middla, Last)		(	Certificate of	Death	1	eg. No.	0.75	4 D11				
F	hysici				Thomas	s, Sr.		2. Date of Dea Month		Yaar 98 6:	of Death				
	/Medic Examir		4a. Fecility Neme (If not Institution, give s	street and number)			4b. City, Town, or L		4c. County of						
			3612 Bonnie Lane Linkwood Dorchester												
	unerai		5. Sociel Security Number 6. Sax	7. Age (In	yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day	9. Birthpiace (Sta Country)	ta or Foreign					
Di	rector		216-16-7988 Usual Rasidance of Decedant	201	77 Y	S.		May 17,	1921 \$	mithvill	e, MD				
land	M til		10a. State 10b. County	10	c. City, Town	or Location				10d. Inside	e City Limits				
Mar	Mar.	ctor	Maryland Dorche	ester		Li	inkwood		'as 2□No						
th th	or 28	Director	10e. Street end Number			10f. Zip Coda		1	0g. Citizan of W	hat Country?					
ath w	238		3612 Bonnie Lane				1835		Unite	d States					
Datitinorey, Maryland Z1Z13-UUZU permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mentel hygiene. Timportant: If them 22 is marked other than *natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Maritel Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 XYes 2 No. If Yas, Giva WW Year or Dates:	r in U,S.	13. Was Decedant of H If Yas, specify Cubs 1 ☐ Yas 2€XNo	Ilspanic Origin? (Sp an, Mexican, Puarto Specify:	pecify Yes or No- p Rican, atc.)		ce - American Indian, ck, Whita, atc. y: White						
5-0 72 ho	Jina Jina	eted	15. Decedant's Educ (Spacify only highast grade	completed)	16a. D	ecedant's Usual Occup Give kind of work dona	pation	kina	16b. Kind of Bus	sinass/Industry					
21215-0020 d within 72 hours af giene.	Mes	Completed	Elamantary/Secondary (0-12)	Collaga (1-4or 5+)	7	ifa. DO NOT use retired	d)								
d N	illed with Hygiene ther the		17. Fathar's Nama (First, Middla, Last)			Bus Driv	7er 18. Mothar's Nam			Transpor	tation				
ylan ylan	c eve	To Be	Tennessee Thomas					Jane Ha		7					
Maryland d 2 should be file th end Mentel Hy	umat		19a. Informant's Name/Relationship (Type	oe, Print)	19b. N	Mailing Addrass (Street			,	Stata, Zip Code)					
1 end 2 Health	end 2 sealth er n 27 is wer frau		Clarence P. Thomas	s, Jr./Son	148	70 Oakland	Road, Ri	dgely, M	aryland	21660					
or he	r oth		20a. Method of Disposition 1 ➡ Burial 2 □ Cremation 3 □ Re	2	Ob. Place of D	isposition (Nama of cramatory or other plea	ce)	Data	20c. Location - 0	City or Town, State					
Baltimore, semit. Peges 1 er Sepertment of Hea	thent of the tant: If the signal or or		4 ☐ Donation 5 ☐ Other (Specify)		Concor			31, 199	8 Feder	alsburg,	Marylan				
Baltimo permit. Pege Depertment	any in		21. Signature of Funeral Sarvice Licenses  22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A.  200 S. Harrison Street, Easton, MD 21601												
			23a. Part1. Enter tha diseasa, or complice shock, or haart failure. List only on	ations that caused the e cause on eech lina.	daath. Do no	t entar tha moda of dyir	ng, such as cardiac	or raspiratory arr	ast,	Approxir Interval	Between				
/Me	sician edical niner		Immediata Causa (Final disease or condition rasulting in death) a	Pulm	0-21	y Edem	4				nd Death				
		2	resuming in dealth)	Due	to (or as a co	4-10-		,							
petn	ansit	Examiner	6 d a d a d a d a d	( or s	estil	De Hear	+ 64.	lune		14	PAC				
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68760,	nysloid he bu	edical	Cause (Disease or injury that initiated events resulting in death) Last		to (or as a cor	nsequence of):	0/719	Perio	2000	ye	40				
- E	ng pr				0		/ '	1							
Box	effending I	lan	d												
P.O.	igned by the e	Physician/M	Part II. Other significant conditions conf	ributing to death but no	en in Part I.	23b. Did tobacco use contribute to the cause of death?  23b. Did tobacco use contribute to the cause of death?  23b. Did tobacco use contribute to the cause of death?									
ds.	p ed t	by						/							
	has been signed 2 should t	Completed						24a. Was a perform	n autopsy ned?	24b. Wara eutop: evailabla pri complation of death?	or to				
	pag.							1□ Y	as 2UNO	1 ☐ Yas 2	No				
VISION Of VITAL Attending Physician: The office of the off	nis certificate ha	Be	25. Was casa rafarrad to medical axaminar?	ospital:		oth Oth	ine	th (Check only or							
		1: To	1 Yas 2 No	28a. Data of Injury	28b. Tin	atient 3L1 DOA	4 LI Nursing H	28d. Dascribe h							
On ding	e fund	ation	Natural 5 Panding invastigation	(Month, Day Yea	ar) Inju		k? Ya <u>s_2</u> ⊟No								
5 6 4	d in by the funer	Certification:	3 Sulcide 6 Could not be datarmined		28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)										
To the Hospital within 24 hours a	etely filled in	edical C	29a. Cartifiar (Check only one)	Ician: To the best of my ar: On the basis of axa and mannar stated.	knowledga, o mination and/o	laath occurred at tha tin or Invastigation, in my o	na, data and placa, pinion, daath occur	and due to the cred at tha tima, d	ause(s) and mar ata and place, a	nar as stated. nd dua to the caus	a(s)				
To the within	completely	Me	29b. Signeture end title of certifiar	7 -	76	29c. Licans	a number	2	9d. Dete signed	(Month, Dey, Yea	100				
			20 Named and 6	1ans	1,0,	ITY	761		10	07/	70				
			30. Name and addrass of person who obs				had de-	MD 2161	2	/					
-	Sta		31. Deta filad (Month, Par, Pear)	32. Register's S	Signatura	St., Cam	йтлаве	עויי באסן							



State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificate	e of	Death		Re	eg. No.	1			
		1. Decedent's Neme (First, Middle	, Last)							2. Date of Deet	h	.735	3. Tima	of Deeth	
Physici /Medi		ANNA			TO	CZYI	OW	SKI		Month Dey Year DECEMBER 26,1998 8:03a					
Examir		4e. Facility Nema (If not institution	, giva street end nu	ımber)						cation of Death	4c. County			Jan	
		WILLIAM HILL H	EALTH CA	RE				EAS	TON		TALI	ВОТ			
Funeral Director		5. Sociel Security Number 164-03-0682	6. Sex 1 ☐ M 2/CXF	7. Aga (In yrs. le 88	est birthday) Yrs.	If Undar Months	1 Yaar Deys		Min.	8. Date of Birth (Month, Dey, ebruary		Coun	elece (Stete etry) Polan	or Foreign d	
and w		Usual Rasidance of Decedent  10e. State 10b. County		10c City	, Town or Lo	cation						140	Od Incide	City Limits	
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within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	edical	(Check only one)	Physician: To the examiner: On the be end men	asis of exemination o	on end/or inv	estigetion,	in my	opinion, dea	th occurre	ed at the time, de	ete end pleca,	end due to	the cause	e(s)	
within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signatura and title of certifier	0.10 111011	1 ^		29c	Licans	sa number		29	9d. Dete signe	d (Month, L	Dey, Year)		
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		30. Name and address of person william H. W					Ven	110 F	aeto	n Martil	and 21	601			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #18,1/7/99, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 29, Virginia Hawkins Waters 1998 2:50pm December /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Village Care & Rehab Center Gaithersburg Montgomery If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 280 F 88 Director 214-32-8540 Maryland Usual Residence of Decedent the Meryland 10a, State 10b. County 10c. City. Town or Location 10d Inside City Limits r than "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Nas 2 No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #1 20877 United States Chestnut Street Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2(X) No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baitimore, Maryland 21215-0020 Specify: à 3 Nidowed 4 Divorced Year or Dates: White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiere. Important: If Item 27 is marked other than "I eny Injury or other treumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary 0 - May Case Sydney Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Justine Brockett-Owens (Niece) 4390 lorcom Lane #410, Arlington, VA 22207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 1/2/99 Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Drive Gaithersburg, MD 20877 Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Ceuse (Final YEARS disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): signed by the aid be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Panding Investigation After Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DECEMBER 30,1998 Hell MO

State Registrar

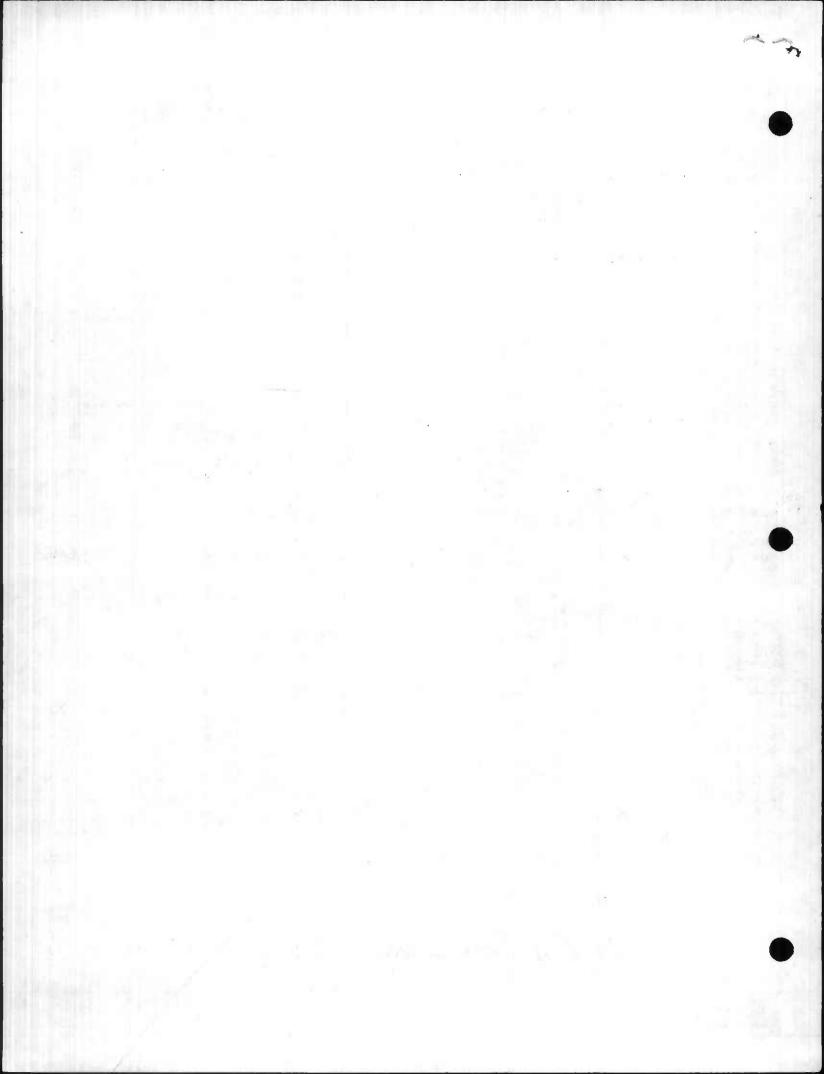
15200 Shady Grove Road #305; Rockville, MD 31. Date filed (Month Pay Year) 32. Redistrar's Signature

Gabriel A. Berrebi, M.D.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

oaks

20850



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician DONALD HATHAWAY WILLIAMS DECEMBER 23,1998 3:15 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 13MM 20 F Yrs. 579-09-5504 FEB. 16,1917 WASHINGTON, D.C Director Usual Residence of Decedent the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at MD. **MONTGOMERY** SILVER SPRING 1 Yes 2 No Director 10e. Street and Numbe 10f. Zio Code 10g. Citizen of What Country? 20906 14646 KELMSCOT DRIVE UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No WWII hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DAIRY TRADE Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) DAIRY TECHNOLOGIST **ASSOCIATION** permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be CHARLES WILLIAMS MATTIE HATHAWAY 0 19e, Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN H. WILLIAMS, WIFE 14646 KELMSCOT DRIVE, SILVER SPRING, MD. 20906 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Buriai 2 Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 12/26/98 ALEXANDRIA, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** BRAINSTEM STROKE 2 DAYS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner ISCHEMIC CARDIONYOPATHY 6 MONTHS attending physician and for use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 certificate be Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 94 signed by t 2 No 3 Probably 4 Unknown END STATE RENAL DISEASE ON DIALYSIS 1 Yea þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed TYPE II DIABETES MELLITUS peen 285 page 2 1 ☐ Yes 2 No 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: or Attending Father death. After 1 Natural 5 Panding 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. To the I within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35045 **DECEMBER 24,1998** 

State Registrar

31. Date tiled (Month)

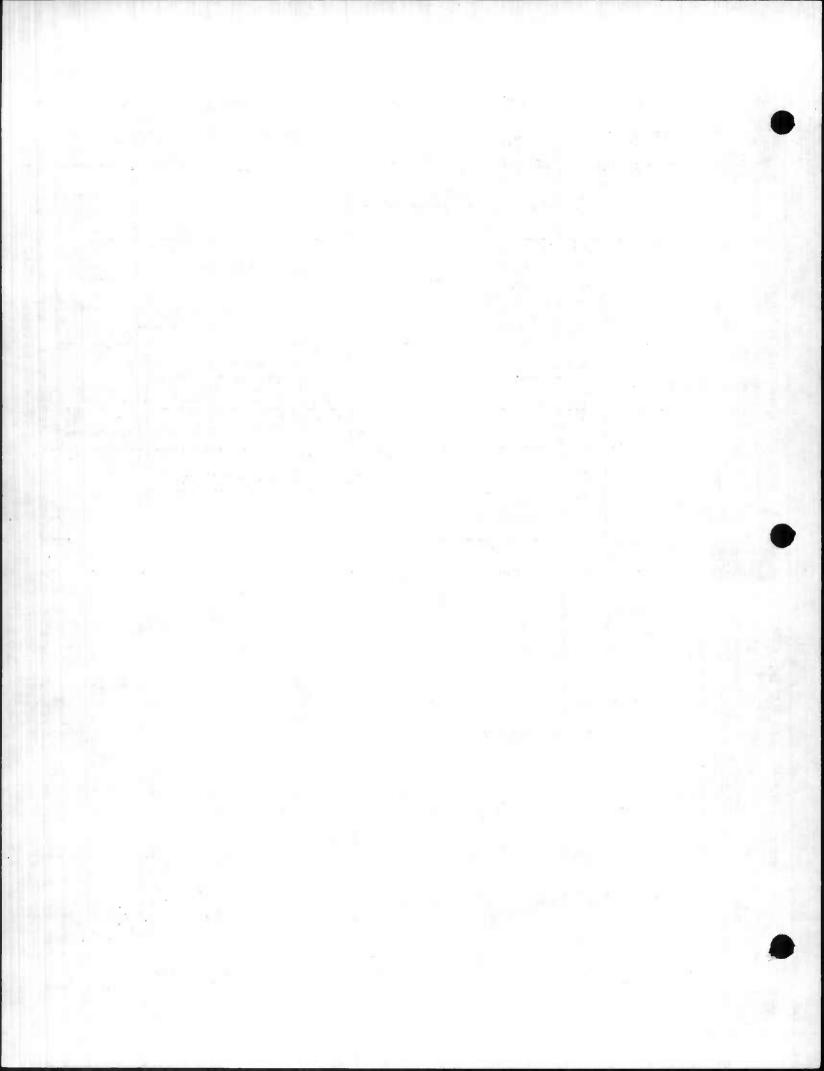
32. Registrer's Signeture

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

1998

DR. PHILIP HENJUM, 3416 OLANDWOOD COURT #204, OLNEY, MARYLAND

20832

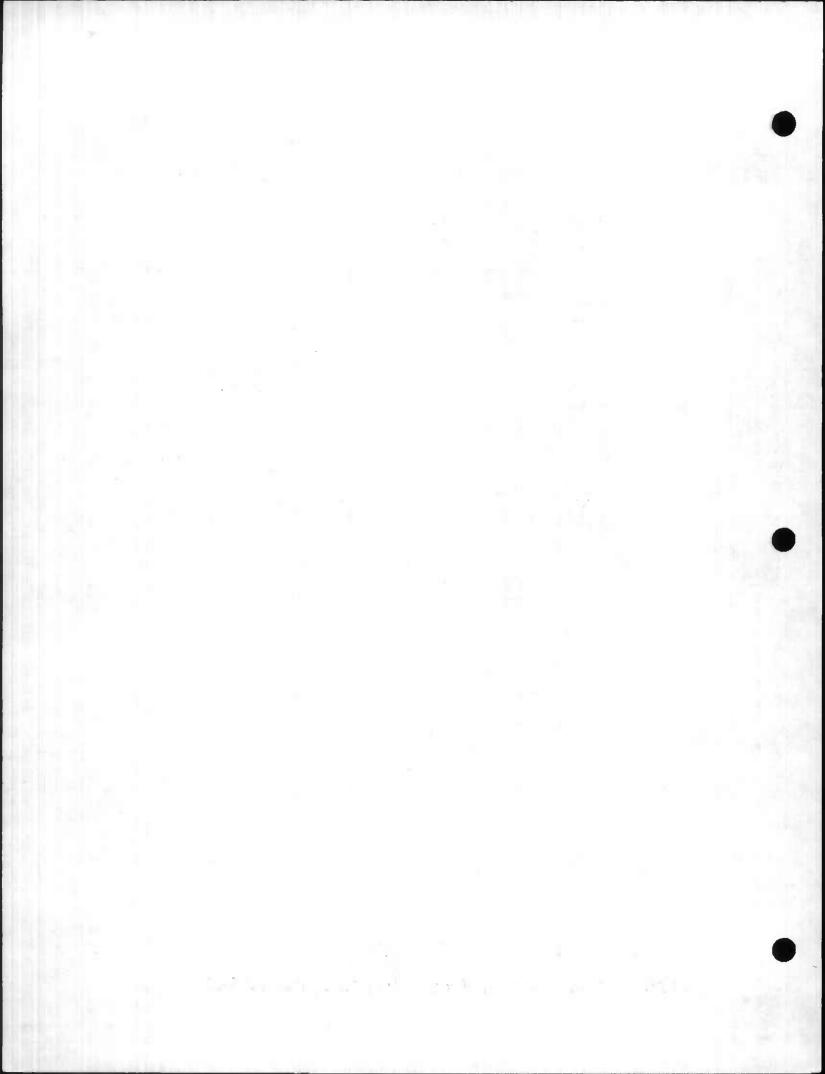


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 28, 1998 8:45 PM JEAN WAGGONER WILSON /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12521 Montclair Drive Montgomery Silver Spring | Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year) | Oct. 5, 1931 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 128-26-1128 Yes Kentucky Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Hedical Examiner must be notified at 1 Yes 2KINo Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 12521 Montclair Drive 20904 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondery (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Physieva Important: if Item 27 is marked other that any Injury or other traumatic event, Item ance. Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme /First, Middle, Last) Be William C. Waggoner Una Safriet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Wilson (husband) 12521 Montclair Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 12/31/98 Silver Spring, MD

22. Name and Address of Facility Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Strond lever 20901 Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Metastatic Lung Cancer 6 weeks Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 6 1 Nes 2 No 3 Probably 4 Unknown d be det Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No To this funeral 28a. Dete of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred edical Certification: 28c. Injury at Work? After t Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 (2) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c\_License number 29d. Date signed (Month, Day, Year) 29b. Signeture and tiple of certifier D43083 December 29, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos Rockville, MD 20850 Modical Conter Dr. #300 32. Registrer's Signeture State Registrar



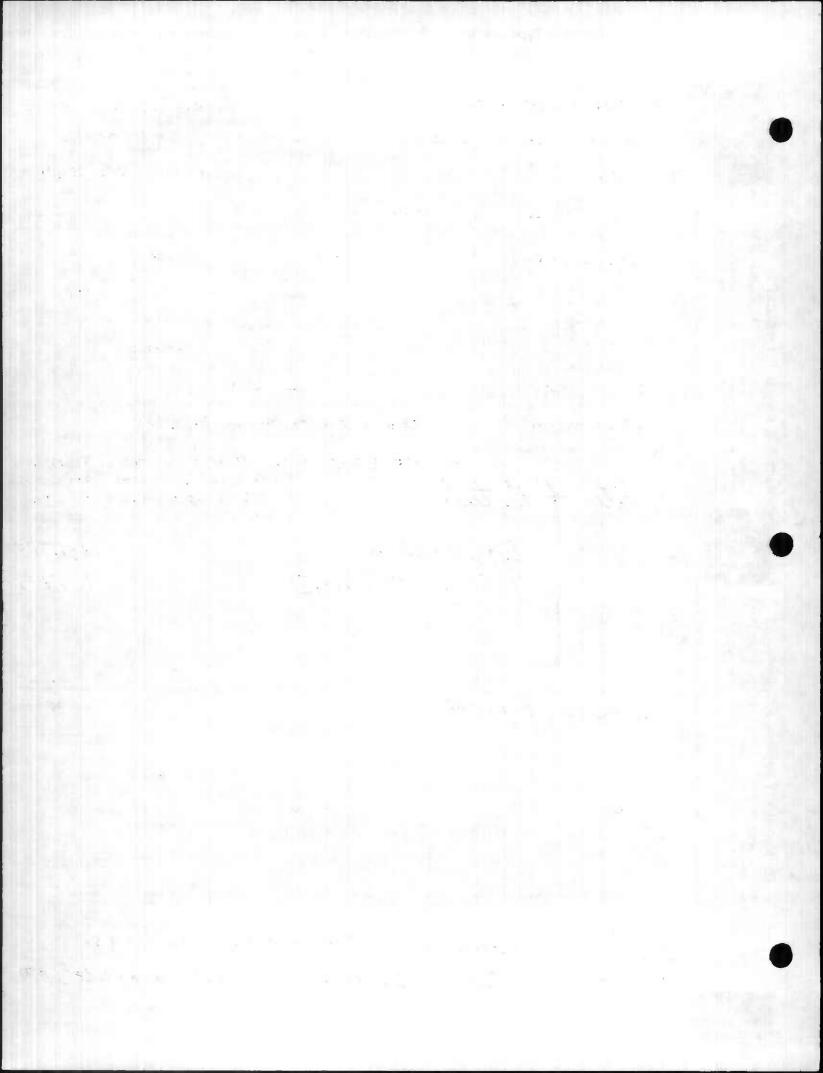
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** GENEVIEVE HACKNEY WOHT. December 21,1998 12:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foraign Country) West Virginia 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1 M 2 CF Aug. 1, 1919 Director 233-07-1981 Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits Hygiene. other than "natural", or items 23s or 28s-f show ent, the Medical Examines must be notified at Fairfax Vienna Virginia 1 ☐ Yas 2√2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 22182 USA 1830 Clifdale Court Funeral deeth 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours efter 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within Eiemantary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Housewife 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Heelth end Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event obce. 17. Father's Name (First, Middle, Last) Be Chloe White Ellis V. Hackney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Paul Wohl/Husband 1830 Clifdale Ct., Vienna, Va. 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 12/29/98 Arlington, Virginia 22. Name and Addrass of Facility Money & King Vienna Funeral Home 21. Signature of Puneral Service License 171 W. Maple Ave., Vienna, Va Iscalle 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter tha moda of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien and the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. that the death certificate be Physician/Medical Due to (or as e consequence of): attending p Part It. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, P. bengis d be del à 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed s certificate headirector, page 2 The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.
I Director: After this certificated in by the funeral director, pages of in by the funeral director, pages. Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours af Funeral D letely filled is Medicai 29e. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the To the Complet 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) 29c. License number D05885 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MONTROSE RD, ROCKVILLE, MD IPSON

State Registrar 31. Date filed (Month, Day, Year)

DEC 3 1

32. Registrar's Signature

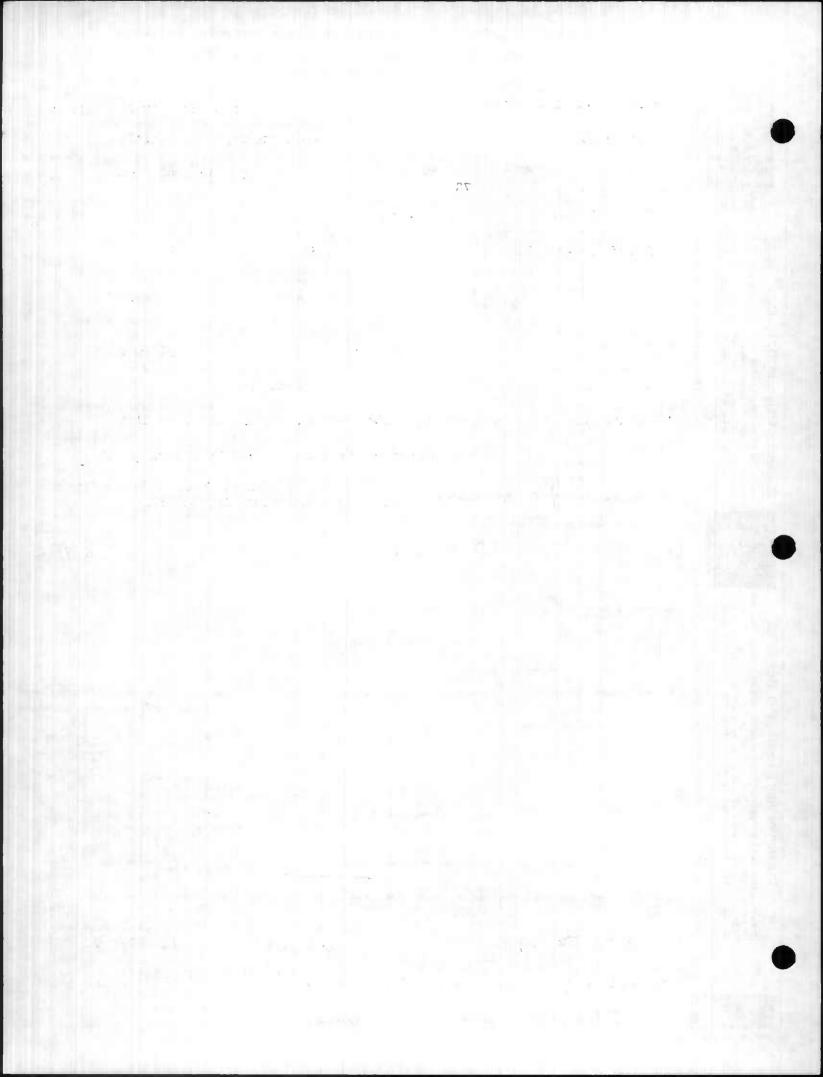
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			State of I	Marylar		artmen ertificat			ind M		giene () Reg. No.	1-) }	0.20	
Phys		1. Decedent's Neme (First, Middle, Walter Augu								2. Dete of De Month Dec 2	Day	Year 98	3. Time of Deeth 2:10pm	
/Me Exan	dical niner	4e Facility Name (If not institution, 2216 Cherokee		er)				b. City, Tov Westm:		cation of Death				
Funera Directo		213-08-6886	5. Sex 7. 1 [X] M 2 □ F		last birthdey, 90 Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, De Dec 18	h y, Year) 1908	9. Birth Con MD	hplace (Stete or Foreig untry)	
Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County Md Carrol	1		ity. Town or L stmins								10d. inside City Limits	
th with the	Funeral Director	10e. Street and Number 2216 Cherokee	Drive			10f. Zip	Code 211	57			10g. Citizen o	f What Co	untry?	
MING X I X I S-UUXU  be filed within 72 hours after death with the Maryland  be filed within 72 hours after death with the Maryland  cheek the Maryland is not them 23a or 28a-f ahow  avant, the Marinal Examples must be indiffed a	by	11. Marital Status  1 Never Married 2 Norrie  3 Widowed 4 Divorced	d 1 Tes 2[	1 Yes 2 No				ispanic Orig an, Mexican Specify:	oln? (Spe , Puerto	ecify Yes or No Rican, etc.)	Ві	ace - Ame leck, White chwhit		
filed within 72 hours at Hygiene. ther than "natural", or mit, the Wedical Exam	Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	grade completed)	College (1-4or 5+)			16e. Decedent's Usuel Occupation (Give kind of work done during most of w life. DD NDT use retired)  cabinet maker			rorking		. Kind of Business/Industry millwork		
Maryland 2 d 2 should be filed th and Mental Hygin T is marked other traumatic avant, ii	To Be Co	17. Fether's Name (First, Middle, La George Wolf	ast)						r's Name	e (First, Middle, Meiden Sumeme)				
		19a. Informant's Neme/Relationshi MIldred Allen		use)						<i>Route Number</i>			ip Code)	
Dallimore, M pemit. Pages 1 end 2 Department of Health a important: if item 27 is any injury or other tra		20a. Method of Disposition  1  Buriel 2 Cremation  4 Donetion 5 Other (Spe	4	20b. Pleca of Disposition (Name of cempetery, cremetory or other pleca)  Meadowridge Memorial						Date 20c. Location - City or Town, State = 1-99 Eldridge, MD				
permit. Departi Importa	9000	21. Signature of Funeral Service Licensee  P.O. Box 195 Sykesville, MD 21784  23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.											Chapel	
Physicia /Medica Examine	at	23a. Par1. Enter the disease, or c shock, or heart failure. List or Immediete Cause (Finel disease or condition resulting in death)		Em	ENTI	A		ng, such as (	cardiac c	or respiretory e	rrest,	1 1 1	Approximete Intervel Between Onset and Deeth	
certificate be executed nding physician and use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b		or es a conse or as a conse									
the death by the ette	Physician/Medi	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use con 1  Yes 2 No										ribute to the cause of death?		
v requires v requires been sign should be	Completed by									24a. Was	en eutopsy omed?		Were eutopsy findings availeble prior to completion of cause of death?	
- 60	Be Com	25. Was case referred to medical	OF Was seen referred to medical										1 Yes 2 No	
. S . O	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2	ER/Outpetie	ent 3 De	DA Oth	or:		me 5 PResi		Other (Spe	cify)	
Attending or death. ector: After by the fune	Certification:	27. Mannar of Deeth  1 Naturel   5 Pending Investigation   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   28c. Injury at								28d. Describe how Injury occurred  28f. Location (Street end Number or Rural Route Number, City or Town, State)			ural Route Number,	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai Cer		Phyeiclan: To the be kaminer: On the basis and menner	of examine										
To the within: To the comple	Med	29b. Signature and title of cartifler	M.D.	orand.		29		336	81		29d. Dete sig	9/0	78	
		30. Name and address of person w	ho completed cause of				-178	4	1380	Progr	ess w	xey.	5-114	
Pogl	itate	31. Date filed (Month, Dey, Year)		strer's Sign	eture		/							

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Owen Leroy Walbert December 17, 1998 8:20a.m /Medical 4e. Fecility Neme (If not institution, give street end number) Chestertown Kenner of Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
Dec. 21, 1924 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Kent & Queen Anne's Hospital 5. Sociei Security Number 6. Sex 1∭ M 2□ F 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 214-28-3725 Yrs. 73 Director Maryland Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23s or 28s-f show 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 ☐ No Funeral Director Maryland Kent Chestertown 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 104 Edge of Town Drive T-2 21620 12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specity Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumema) Wilbur W. Walbert Beatrice Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health e If item 27 is or other tra Jean Victoria Whitlock Walbert 104 Edge of Town Drive T-2, Chestertown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removal from State Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 12/20/98 Rock Hall, Maryland 21. Signeture of Funeral Seryice Licensee 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Perti. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest.

130 Speer Road, Chestertown, MD 21620 Approximate shock, or hear feliure. List only one cause on each line. Rins Physician Lower GI Bleed immedieta Cause (Finel diseese or condition rasulting in deeth) /Medical STAIL BY Examiner Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): KNOWN Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): page 2 should be deteched for use as Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco usa contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Wera autopsy findings evelleble prior to complation of cause of death? 24e. Wes en eutopsy performed? this certificate 2 No 2 1 No 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes Certification: To funeral 27. Manner of Deeth 28e. Date of injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? After 1 Naturei 5 Panding investigation death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homlcida within 24 hours a To the Funeral D completely filled Hospital 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. Medical 2 Madical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, daeth occurred at the time, dete end piece, and due to the cause(s) and menner stetad. 296. Signeture end tille of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) An 30. Nama and address of person who completed cause of daeth (itam 23a) (Type, Print) Road SPEEN CHESTERTOM 21620 mil 82, Ragistrar's Signatu State Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month 27, DECEMBER 2:30 AM VALENTINA ZACHWALYNSKYJ 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARINER HEALTH CARE OF SILVER SPRING SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign 10 M 20 F Months Yrs. JAN. 27 1903 155-24-6751 UKRAINE Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No 10e. Streel and Number 10f Zip Code 10g. Citizen of What Country? 709 BURNT MILLS CT. 20901 UKRAINE 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Datas: 1 □ Navar Married 2 □ Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FEDOR POPOV **UNOBTATNABLE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHAN MAKSYMJUK (SON IN LAW) 709 BURNT MILLS CT. SILVER SPRING, MD 20901 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Method of Disposition ST. "ANDREWS" CHURCH OR THODOX CEMETERY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State UKRAINIAN 12-30-98 SOUTH BOUNDBROOK, NJ 4 Donation 5 Dolher (Specify) 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwaen Onset and Death Immediate Cause (Final disease or condition resulting in death) MEMMONIA Due to (or as a consequenca of): MULTI INFACT Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DUGGSTIVE HEART FAILURE 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Avatural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - Al home, farm, street, factory, offica bullding, etc. (Spacify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tilla of certifier 29c. License number 29d. Dala signed (Month, Day, Year) D08944

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturel", or iten any injury or other traumetic svent, the Medical Example Quee.

Physician

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Examiner

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Division of Vital Records, P.O. Box 68760,

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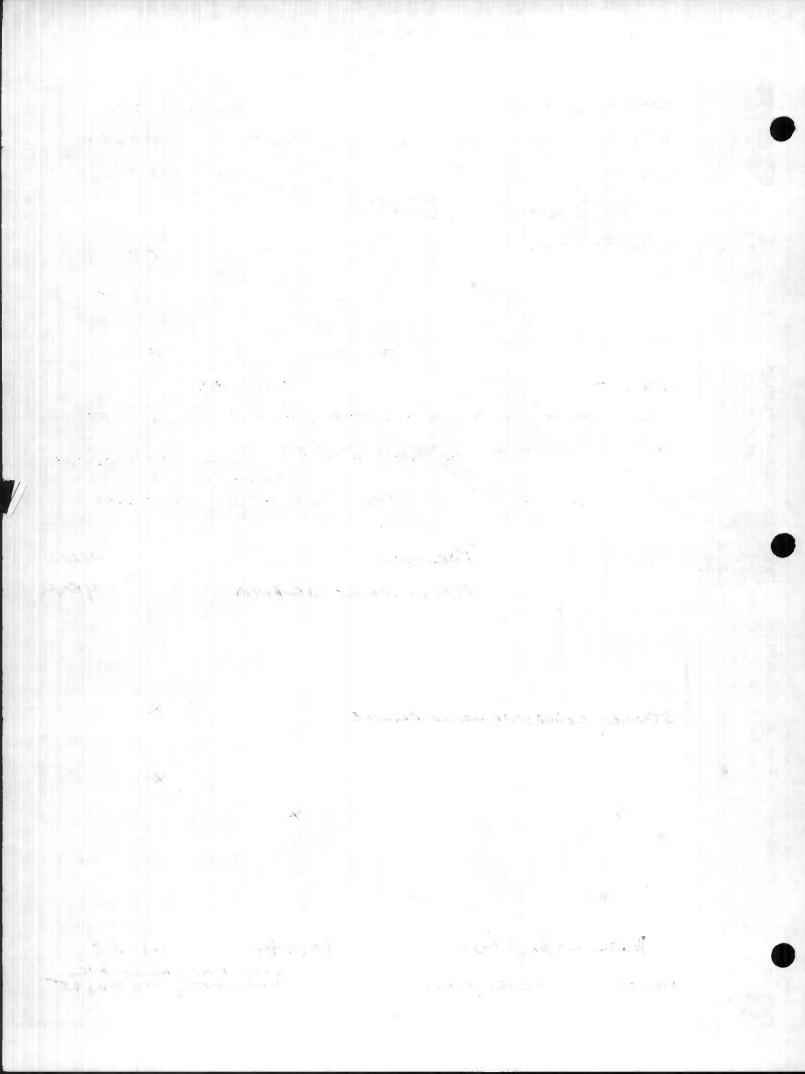
SHARGEL M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAMMAGUT

KENSING-70N,

26802 CH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Item 1 Per PHY Film G767 1-13-99 Reg. No rja 3. Time of Death 1. Decedent's Nema (First, Middla, Last) 2. Deta of Deeth Month **Physician** CONREY BRONDA 12 0910 AM Brenda L. Conrey /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner WORKESTEC. BERLIN Atlantic GEneral Hospital if Under 24 Hrs. B. Deta of Birth (Month, Day, Year) 10/30/42 Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 M 2 X F Monihs Days Yrs. 220-38-1998 56 Wash, D.C. Director Usuai Rasidance of Decedant 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location Snow Hill Md. Worcester 1X Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 104 N. Collins St. 21863 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2% No if Yas, Giva Yeer or Detes: Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian. 11 Maritai Status Biack, Whita, atc. 1 Navar Married 25 Merried 1 Tyas 2 TNo Specify: Specify: white b 3 ☐ Widowed 4 ☐ Divorced 16a. Decedani's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Worcester County Elemantary/Secondary (0-12) Collega (1-4or 5+) Hygiene. treumatic event, the Development Center 12 House councelor 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) Mental marked William B. Hardy Catherine Anderson Hardy 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) 104 N. Collins St., Snow Hill, Md. 21863 Michael Conrey of Health Baltimore. 20a, Meihod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Deie 20c. Location - City or Town, Stete Department of Important: If it any injury or c 1 ☐ Buriel 2 Cramation 3 ☐ Ramovel from Steta Salisbury Crematory 1/1/99 Salisbury, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licensee 22. Neme end Address of Fecility P.O. Box 87 -Llennis Dennis Funeral Home, Snow Hill, Md. 21863 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heer failure. List only one cause on each line. **Physician** /Medicai Immediata Causa (Final Bronchiogenic CARCINOMA 8 months diseasa or condition rasulting in daath) Examiner Examiner Sequantially iist conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disaasa or injury Dua to (or as a consequence of) Physician/Medical Due to (or as a consequence of). resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part tf. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy 1 Yes 2 No 1 TYes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannef of Death 28d. Describe how injury occurred 28b. Time of 28a. Data of Injury (Month, Dev Year) 28c. Injury at Work? Certification: 1 Naturai 5 Panding 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homlcida 24 hours 1. Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the ceuse(s) and mannar ss stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and mannar stated. 29a. Certifier (Check only one) To the F within 2 To the F 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 12/28/98 H44283 physic/2

State Registra

ROBERT J. DURKIN D.O. 9733 32. Replatrar's Signatura

30. Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print)

Healthway DR. Berlin MD 21811 Docks

monde

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 4a per M.D G-767 1/13/99 reb Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 3:10 A.M. Agnes Loeschke December 27, 1998 4e Facility Neme (If not institution, give street end number) Court 4b. City, Town, or Location of Deeth 4c. County of Death 32 Turbin Street Thurmont Frederick If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) November 17, 1897 If Under 1 Year 5. Societ Security Number 7. Age (In yrs. last birthdey) 101 Yrs. Birthplece (Stete or Foreign Country) Maryland Deys 214-22-5325 1 M 2 KF Months Yrs. Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits Frederick Maryland **Thurmont** 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21788 32 Turbin Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indien. 11. Maritel Status Bleck, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Valentina Suchanck John Conrad Thomas Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2933 Woodwick Court Ellicott City, Maryland 21042 19a. fnforment's Name/Reletionship (Type, Print) Mr. Richard J. Loeschke/Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date Buriel 2 Cremetion 3 Removatirom Stete 12/30/98 Baltimore, Maryland Lorraine Park Cemetery 4 ☑ Opnetion 5 ☐ Other (Specify) 2 Sign Jure of Fun al Service Licensee <sup>22. Name and Addiss of Facility</sup>me, P.A. 3871 Old Columbia Fike Ellicott City, MD 21043 MO0535 and. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximete interval Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in death) rele Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed?

**Physician** /Medical Examiner

permit. Page Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

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**Funeral** 

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiane. Interfer them 27 is marked other than "naturel", or frems 23a or 28a-f show any or other treumstic event, the Madical Example matter and all any or other treumstic event, the Madical Example matter and any or other treumstic event, the Madical Example matter and any or other treumstic event, the Madical Example matter and any or other treumstic events.

Baltimore, Maryland 21215-0020

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Examiner Physician/Medical

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

(Check only one)

29a. Certifier

1 Maturai

Certification: To 24 hours aft Funeral Di letaly filled in

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edical

that the death certificate be executed Attending Physicien: this funeral After death. Direc

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Hospital

within 2 To the F

Division of Vital Records, P.O. Box 68760

State Registrar

25. Was case referred to medical

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28a. Dete of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

29c. License number

ST-

30. Name and address of person who completed ceuse of deeth (ttem 23e) (Type, Print)

m.D 31. Date filed (Month, Dey, Year)

JAN 1 3 1999

32. Registrer's Signature

**DHMH 16 Rev 6/95** 

completion of cause of death? N/4.

1 ☐ Yes 2 ☐ No

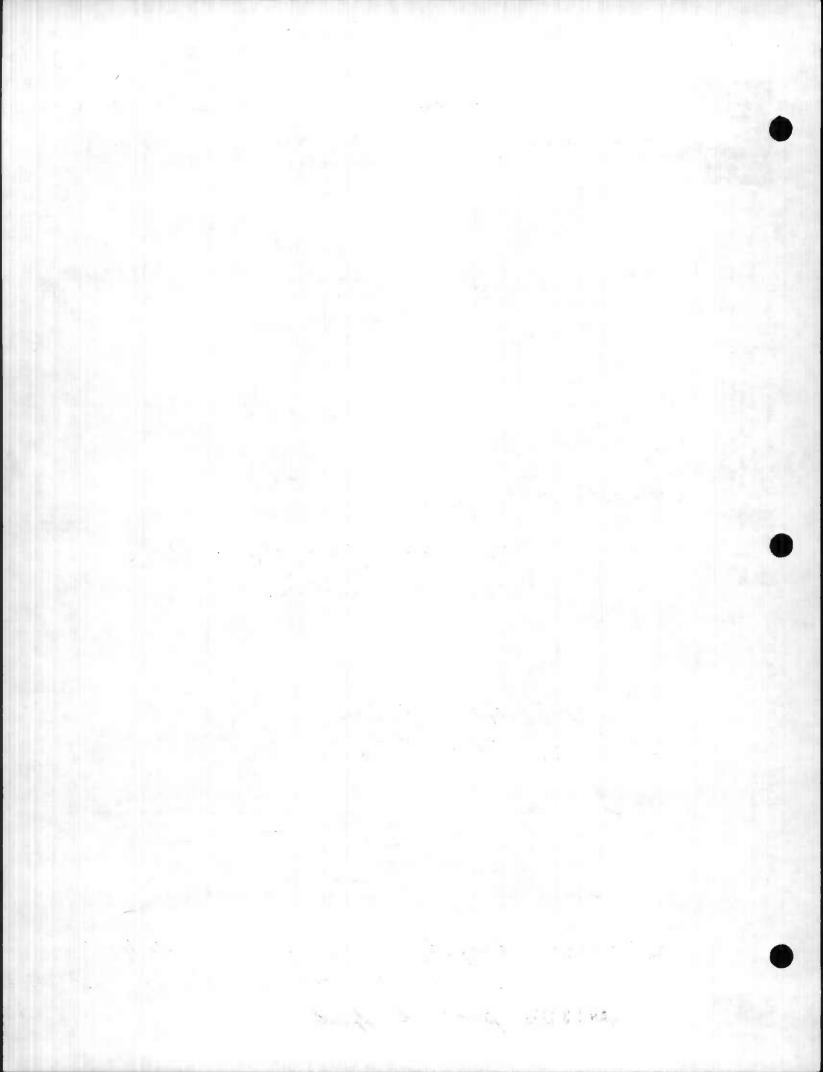
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 🕒 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es steted. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year)

1 X00 3 3 10 No

HURMONT, MD.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item 24a Per PHY Film G767 1-13-99 rja Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death r 29, 1998 **Physician** Florence Powell December 4:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 302 S.Pennsylvania Avenue Delmar Wicomico If Under 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) Feb. 27, 1907 6 Say 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF 91 Months Days Hours Min 214-18-4441 Yrs. Director unknówn Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Maryland Wicomico Delmar 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 302 S. Pennsylvania Avenue 21875 U.S.A. Funeral death 12. Was Decedant Ever in U.S.
Armed Forces? UNKNOWN
1 ☐ Yes. 2 ☐ No
If Yes, Give
Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame) Be Unknown Unknown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. Unknown 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 DOther (Specify) In state 21. Sign ure of uneral Service Licensee Wade, State Anatomy Board, 655 W. Baltimore Street Director aclo Baltimore, Maryland 21201 art 1. Enter the dillease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner and il-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician a P.O. Box 68760 100 Physician/Medicai Due to (or as a consequence of) attending for use as signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of geath? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peed ils certificata ha 1 Yes 244 W 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nasidence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Aftar 5 Pending investigation 1 Hetural 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) To the Hospital or A within 24 hours after To the Funeral Direc completaly filled in by 4 I Homicide 1 certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(a) and manner as stated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one)

29c. License number

1104 Itealthway Dr

29d. Date signed (Month, Day, Year)

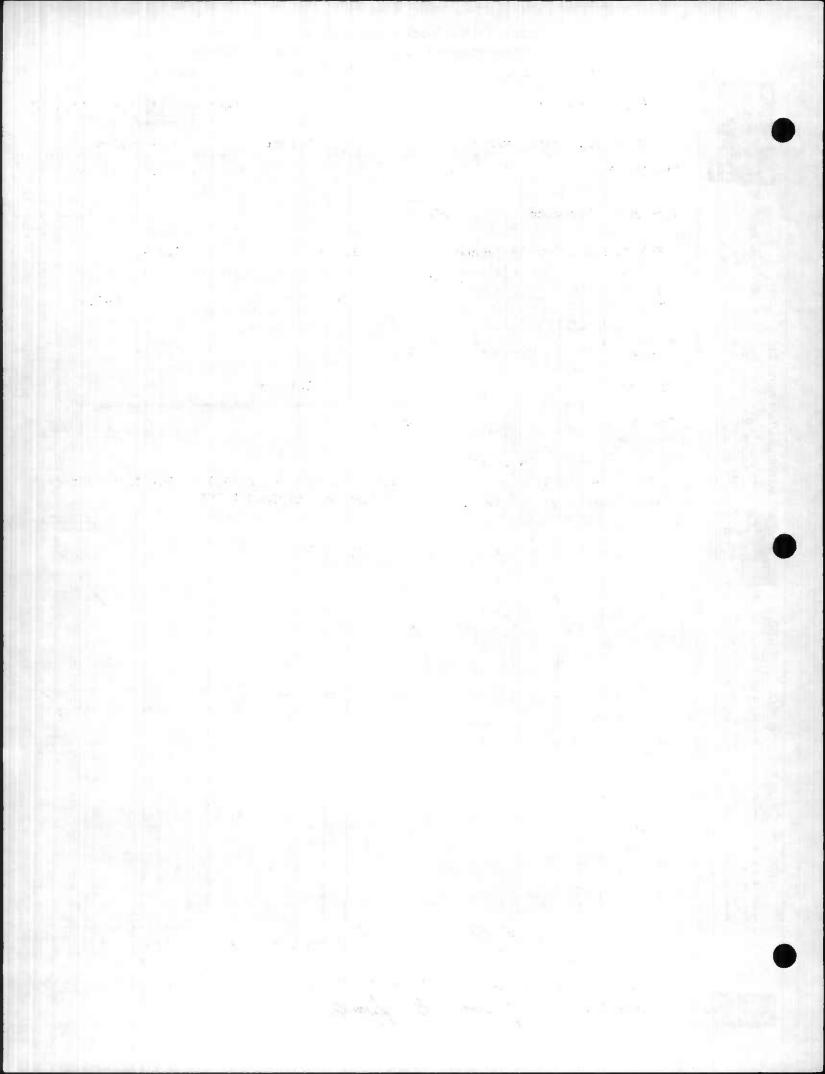
State Registrar 29b. Signature and title of certifie

il ham 31. Data fliad (Month, Day, Year)
JAN 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

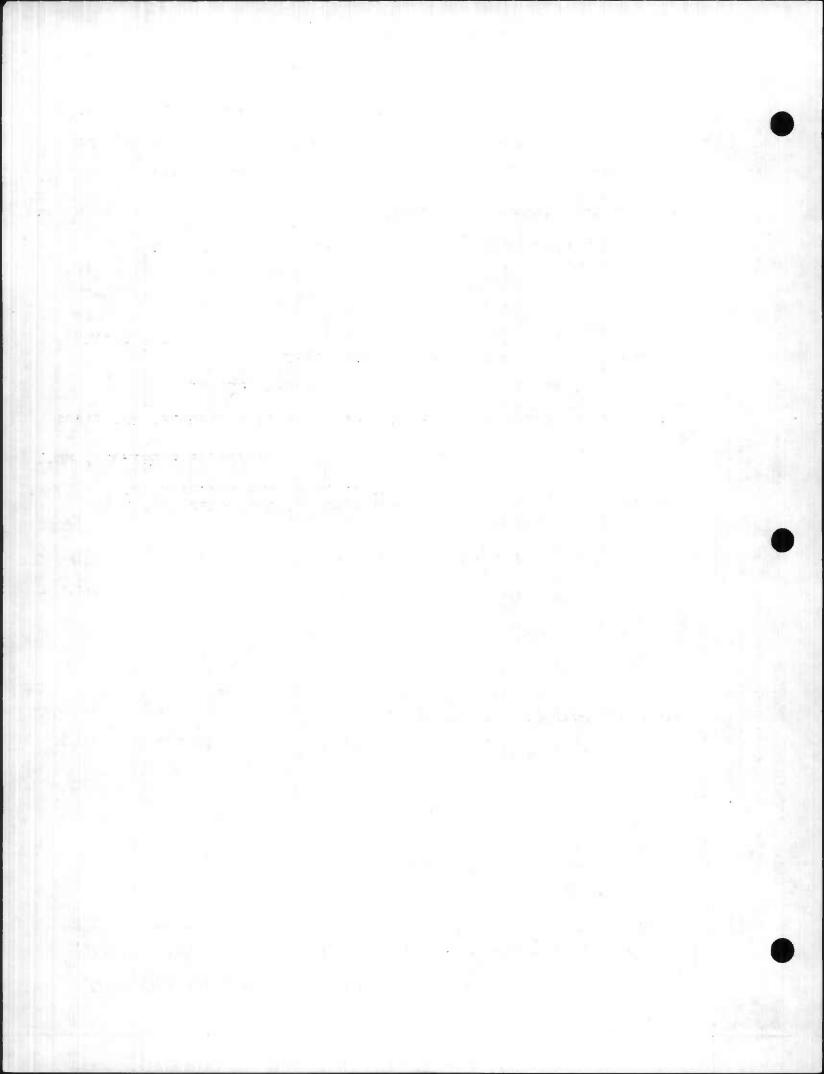
Robins

32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Physician Year 23 1998 5:39 am /Medical SARAH COLLINS DEC 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE 36 LINCOLN PARKWAY ANNAPOLIS
If Under 1 Year | If Under 24 Hrs. | ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 25F Yrs. 227-07-2520 Director 81 MAY 13 VIRGINIA **Usual Residence of Decedent** 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 36 LINCOLN PARKWAY 21401 US Nerra 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Detes: 1 Never Married 2 Merried netural, or altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglans. DR. WILLIAM Elementery/Secondary (0-12) College (1-4or 5+) COLLINS 12th 2 yrs. DENTAL HYGIENIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if hem 27 is merised oth any injury or other traumatic avent ands. Be ANDREW Y. MERRITT ETHEL HEWITT 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HANNAH FINNEY (SISTER) 36 LINCOLN PARKWAY ANNAPOLIS, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORY 12/29/98 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. Lavry D. Beese 821 WEST ST enter the mode of dying, such as co ANNAPOLIS pardiac or respiratory arreit, 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart feilure. List only one cause on each line. **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): for use as signed by the aid be detached for P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? with Right 1 Yes 2 No 3 Probably 4 Unknown þ Records, Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? page 2 HI Yes 200No 1 Yes 2 No Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending 1 DiNatural death. To the Hospital or Attandit within 24 hours after death. To the Funeral Director: A complately filled in by the fu Investigation 1 Tyes 2 No 2 Accident 8 Could not be determined 3 Suicide 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 2003 mo 32. Redistrar's Sign 31. Date filed (Month, Day, Year) DEC 2 8 1998 State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death 4b. City, Town, or Location of Death LORRAINE ENNIS 1998 4c. County of Death 1655 4a Facility Name (If not institution, giva street and number) ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Yeer | If Under 24 Hrs. | 8 Months | Deys | Hours | Min. | ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1□ M 2□ F 213-46-1066 NOV. 6 1946 MARYLAND 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yas 2 ☐ No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1901 G. COPELAND STREET 21401 US 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritei Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th MACHINE OPERATOR Name (First, Middle, Maidan Surmema) FIBER CO. 17. Father's Name (First, Middla, Last) CLARENCE ENNIS MILDRED WORMLEY 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 1155 MADISON ST. APT.A2 ANNAPOLIS, MD. 1403 LaDON CARTER (DAUGHTER) 20b. Place of Disposition (Neme of cemetary, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HILL CREST CEMETERY 12/28/98 ANNAPOLIS, MD. 22. Neme and Address of Fecility WM. REESE & SONS MORTUARY, P.A. 21. Signeture of Funeral Service Licenses any 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications het caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting In death) 6 945 (ab Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was an autopsy completion of cause of death? 1 Tes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2000 Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Phpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 Yes 2 No investigation

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**Physician** 

\* /Medical

Examiner

**Funeral** 

**Director** 

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ant: If item 27 is marked other than "naturel", or flet ury or other traumatic event, my Mad call Examined.

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altimore, Maryland 21215-0020

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Physician/Medical à Completed Be P

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P.O. Box 68760, Division of Vital Records, The Hospital or Attending Physician: funeral director, After this 24 hours after deeth.

Funeral Director: A filled in by

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3 Suicide

(Check only one)

29a. Certifier

Registrar

8 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of pertifier 29c. License number

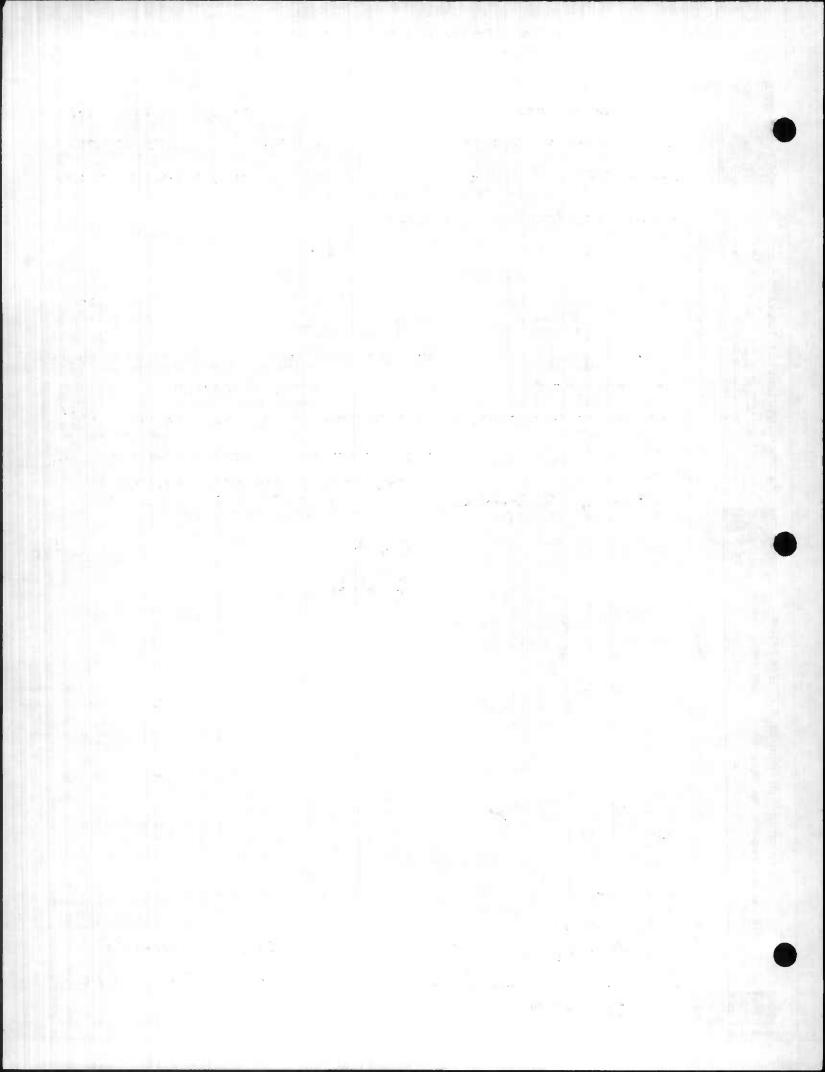
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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

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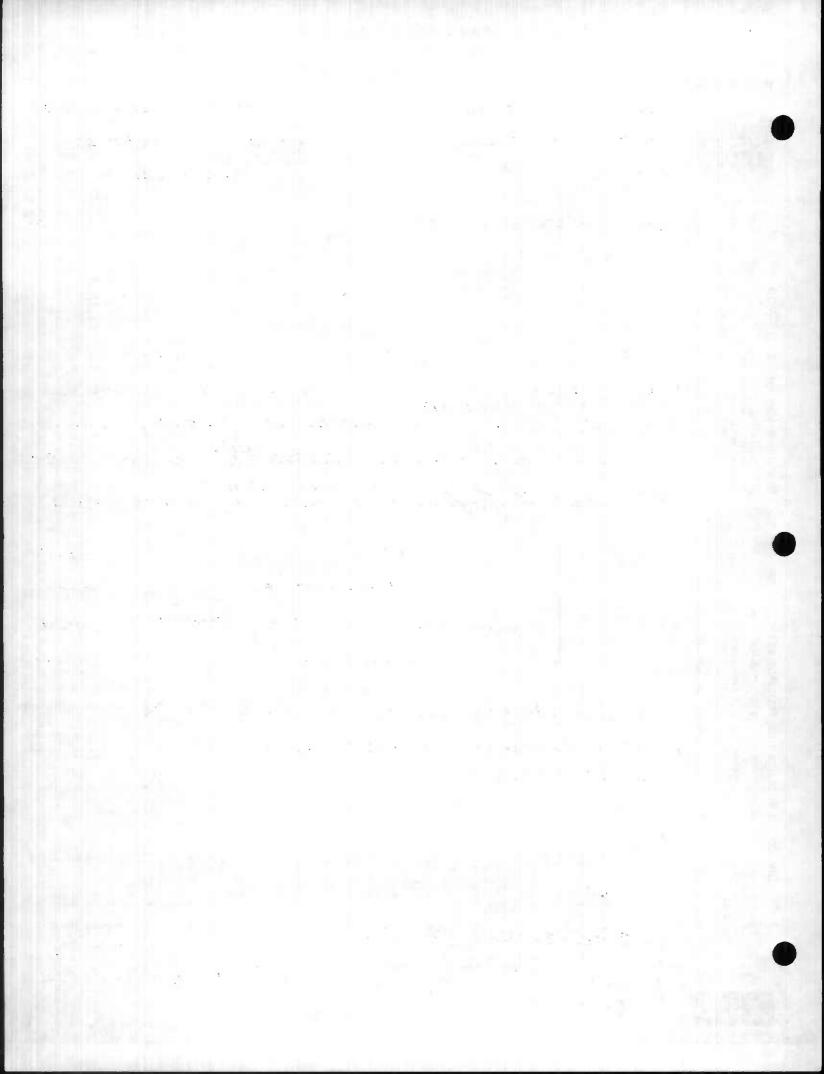
32. Fegistrar's Signature 31. Dete filed (Month, Day, Year) DEC 2 8 1998

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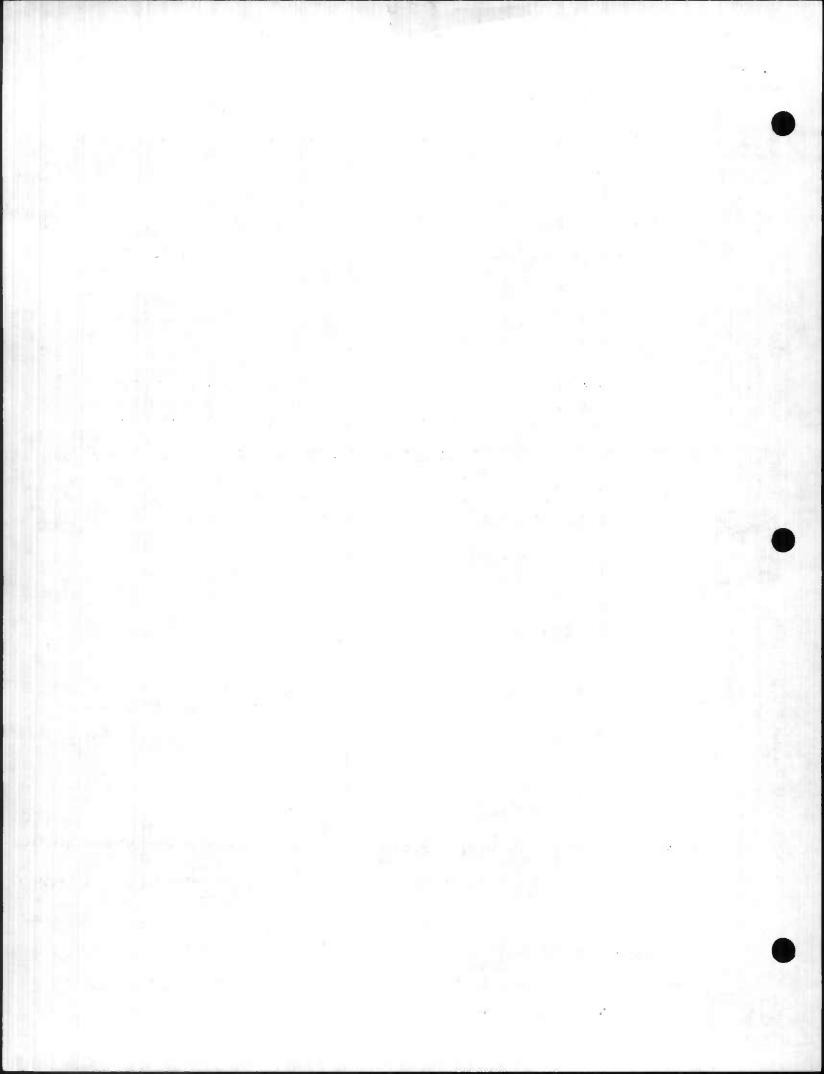
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JAMES FRANKLIN	SR.	State of Marylan	d / Departme				giene 8	4 1	05			
Physician	Decedent's Name (First, Middle, Last)     LEVI JAMES		SR.			2. Date of De Month DECEMB	ath Day	ime of Death				
/Medical Examiner Funeral Director	4a Facility Name (If not institution, give s SOUTHERN MARYLAND I 5. Social Security Number 6. Sex 217-44-4478	HOSPITAL CENT		der 1 Year	CLINTO If Under 24 Hr Hours Mir	N S. S. Dete of Birth	4c. County of Death PRINCE GEORGE  1. (Year) 9. Birthplece (Secontry)					
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Ore, M	LUCY FRANKLIN / W  20a. Method of Disposition  1 \( \times \text{Disposition} \)  4 \( \times \text{Disposition} \)  5 \( \text{Other (Specify)} \)	20b. P	P.O. BOX lace of Disposition (I emetery, crematory of NITY MEMOR	Name of or other place)		Date 1/7/99	20c. Location -	0646 City or Town, SI				
Baltim permit. Pag Department Important: end Injury	21. Signature of Furreral Service Usensee  22. Name end Address of Facility  THORNTON FUNERAL HOME, P. A  147DIA C. THORNTON JOHNSON  3439 LIVINGSTON ROAD INDIAN HEAD, MD 2064											
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart feilure. List only on Immediata Causa (Final disease or condition resulting in death)	hulphe		5	such as cardi	ac or respiratory at	rest,	Interv	oximate val Between et snd Death			
K 68760, Millicate be executed ing physician and see the bunel-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		r as a consequence of				H	1				
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IVISION TATORINA THE THE THE THE THE THE THE THE THE THE	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	28f. Location (S City or Tox	DRIVER OF COR COLLOGO WITH T 281. Location (Street and Number or Aural Route Number. City or Town, State) 301+CEDAQUIUF RD PRIME GEDEUS							
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within To the comple	29b. Signature and title of certifier	and manner states.		29c. License r	umber		29d. Date signed	d (Month, Day, Y	(ear)			
	Mayre Breth	ule		0.C.	M.E.		JANUARY	1,1999				
	30. Name and address of person who con  HOW DMOD 5. (4)  31. Date filed (Month, Day, Year)	mpleted cause of death (Item COVEW JUM), 32. Registrar's Signal	11	1 Penn	Stree	t, Baltir	more, Ma	ryland	21201			
State Registrar	JAN 04 199	9 September 5 Signal	B. A.	porke	/							

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene A Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 26, **Physician** 1998 6:50 pm Mary Margaret Fox Dec. · /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Genesis Eldercare Severna Park Anne Arundel If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) April 13, 1923 If Under 1 Year 5. Sociel Security Number 9. Birthplece (Stete or Foreign 7. Age (In yrs. lest birthdey) **Funeral** 316-16-7596 Months Deys 1 M 20 F 75 Yrs Indiana Director Usual Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD 1 ☐ Yes 2 No Anne Arundel Severna Park Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 709 Laurel Lane 21146 USA deeth Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus pernit. Peges 1 end 2 should be filed within 72 hours after of Depertment of Heelth end Mental Hygiene. Intportant: If Item 27 is marked other than "natural", or Item 1 Yes 2 No It Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Neme (First, Middla, Maiden Surname) 17. Fether's Neme (First, Middle, Last) William Roth Gertrude Senn 19b. Meiling Addrass (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) 19e. Intermant's Neme/Reletionship (Type, Print) 711 Laurel Lane Severna Park, MD 21146 Kevin Fox / Son other t Dete 30 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, Slete Dec 30 1998 1 Buriel 2 □ Cremetion 3 □ Removel from State any injury or MD Veterans Cemetery Crownsville, MD 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility
Barranco & Sons P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. If tar the dia a complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence ot): Examiner neumoni physician and the burial-transit Sequantially list conditions, if eny, leading to Immediate cause. Entar Underlying Causa (Diseese or Injury thet initieted events resulting In deeth) Last Due to (or es e consequence ot) certificate be execu Division of Vital Records, P.O. Box 68760, dysohas Physician/Medical Due to (or as e consequence of): einers Disease 86 advance 950 0 23b. Dfd tobacco use contribute to the cause of death? ed by the detached Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown g 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed completion of cause of deeth? page 2 s has 2 No certificate 1 ☐ Yes 2 ☐ No 25. Wes case raterred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Othar: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatiant 2 ER/Outpatlant 3 DOA this funeral 28c. Injury at Work? 28d. Describe how Injury occurred 27. Mennar of Death 28h. Time of Certification: 28a. Date of Injury (Month, Day Year) After 1 Natural
2 Accident or Attending 5 Panding Investigation eftar death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, fectory, office building, atc. (Specify) 4 Homicida 24 hours e Funeral D Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

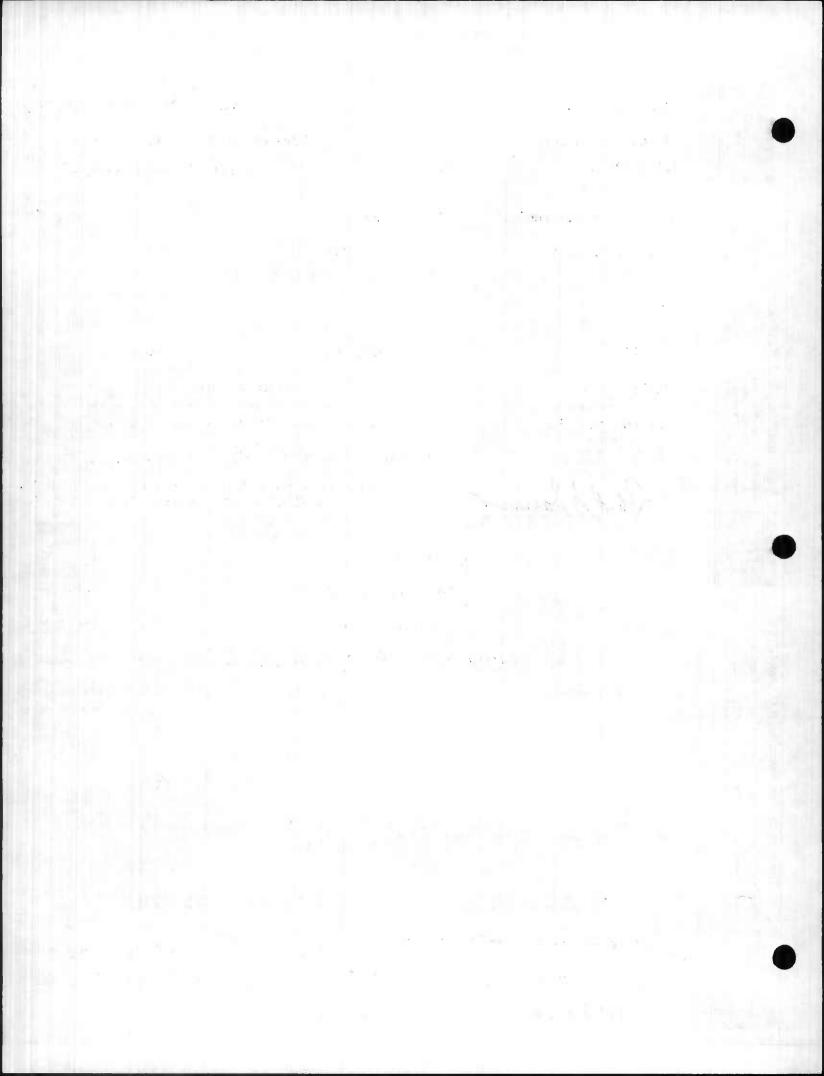
Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fund completaly fi (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Police Coa From MD 1454 B4 A

Registrar DHMH 16 Rev 6/95

State

31. Dete tiled (Month, Dey, Year) DEC 2 9 1998

32. Registrer's Signature



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Helen Augusta Gross 1998 1322 Dec 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County oi Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year II Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) Days Months 1 □ M 2 🗗 F 219 16 1512 86 Yrs 10/15/1912 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Anne Arundel 1 Yas 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1010 Tallwood Road #TC 21403 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede com 16b. Kind of Business/Industry rede completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) State Of Maryland Dietician 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Dorsey Isabella Hesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frank Simms (son) 1010 Tallwood Rd #TC/Annapolis MD 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/30/98 21. Signature of Funeral Service License 22. Name end Address of Facility Melanie Wilhelm Advent Funeral & Cremation Services 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical **Examiner** 

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P.O. |

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Division of Vital Hospital or Attending Physician:

permit. Pages 1 and 2 s Department of Health er Important: If Item 27 ia any Injury or other trau once.

**Physician** 

Examiner

**Funeral** 

Director

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Examiner must be notified at

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Pages 1 and 2 should be filed within 72 hours effer on on of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or item

Baltimore, Maryland 21215-0020

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Physician/Medical Examiner g Completed Be Certification: To

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28i. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

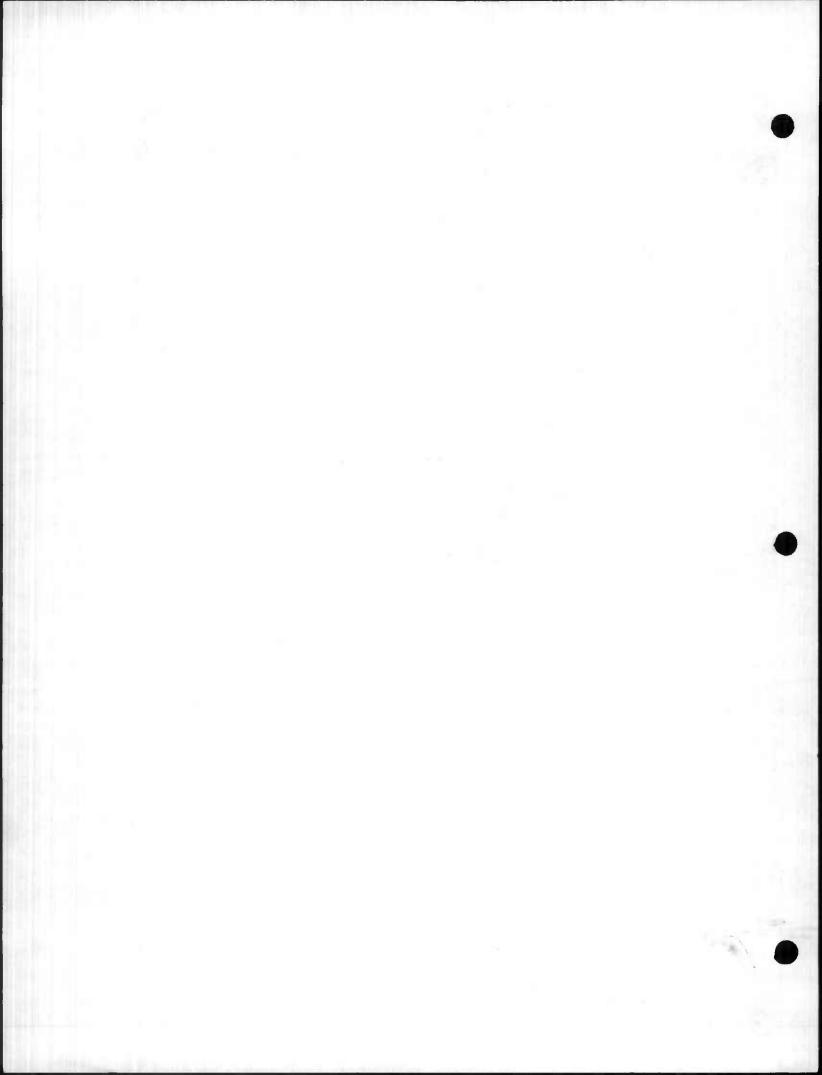
State Registrar

edicai

EN, M.D., 600 RIDGELY AVE., ANNAPOLIS, MD 2140 Scott

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

30/98



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend. #14 1/7/99 AM AACO Health State of Amend. #20b 12/30/98 SM AACO Health Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yası **Physician** MALCOLM (NMN) HARRISON DECEMBER 22. 1998 9:00 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IVY LANE GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) If Under 1 Yaar If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months 10 M 20 F Days Yrs 417-32-2831 73 Director 10/24/25 **ALABAMA** Usual Residence of Decedent Pages 1 and 2 should be illed within 72 hours after death with the Maryland nant of Health and Mental Hygiena.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other treumatic avant, the Medical Examinations must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director ANNE ARUNDEL MD GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 IVY LANE 21061 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX as 2 □ No If Yes, Give Year or Dates: 1949-74 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, atc. 1 Never Married 2 Married 21215-0020 Specify: BLACK 1 ☐ Yas 2KMo Specify: PY 3 ☐ Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECURITY DEPT. OF DEFENSE 12 Baltimore, Maryland 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) JIM HARRISON CALLIE SMITH 19a. Informant's Name/Relationship (Type, Print) ( DAUGHTER 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) NATASHA CASSANDRA HARRISON 103 90 FAULKNER RIDGE CIR., COLUMBIA MD, 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 12/29/98 Warial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 12/31/98 CROWNSVILLE, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 a a Rack 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown Records, P 24b. Were autopsy findings available prior to completion of cause of death? paga 2 should Medical Certification: To Be Completed 24a. Was an autopsy performed? certificata has 240 No 1 Yes 1 ☐ Yes 2 ☐ No ardian Division of Vital 25. Was case referred to medical examiner? or Attanding Physician; after death.

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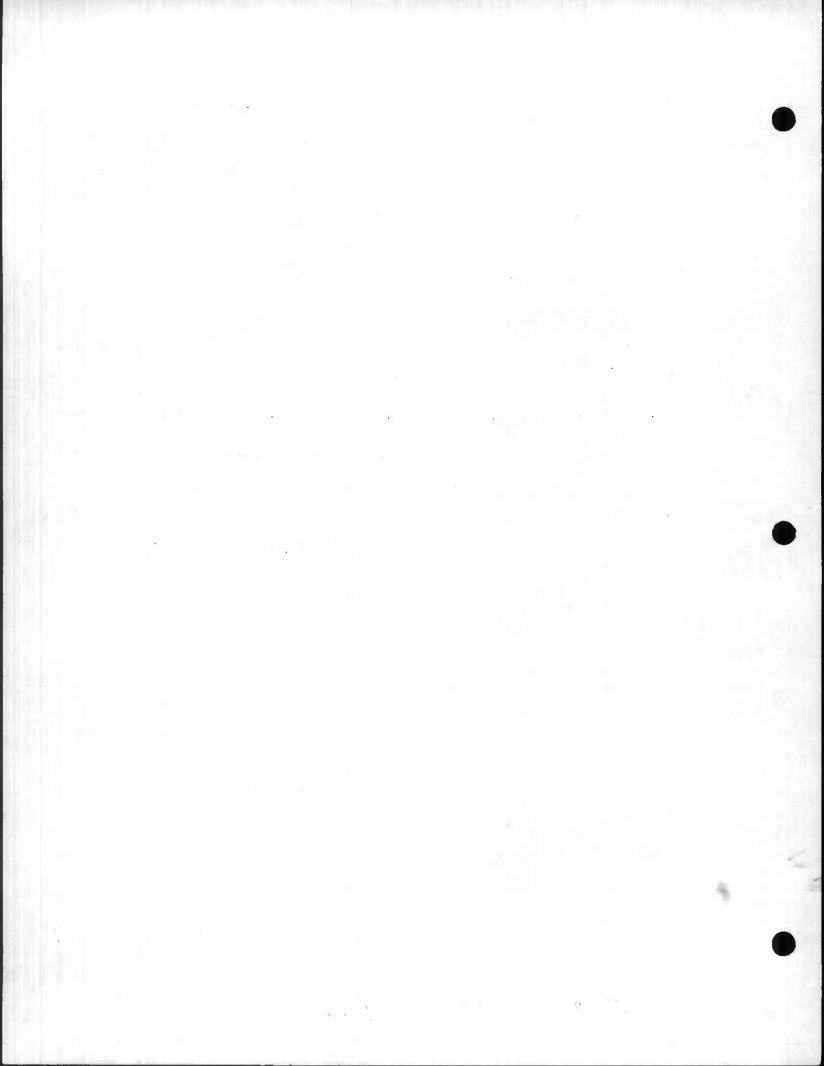
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) DEC 2 8

DHMH 16 Rev 6/95

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signatura

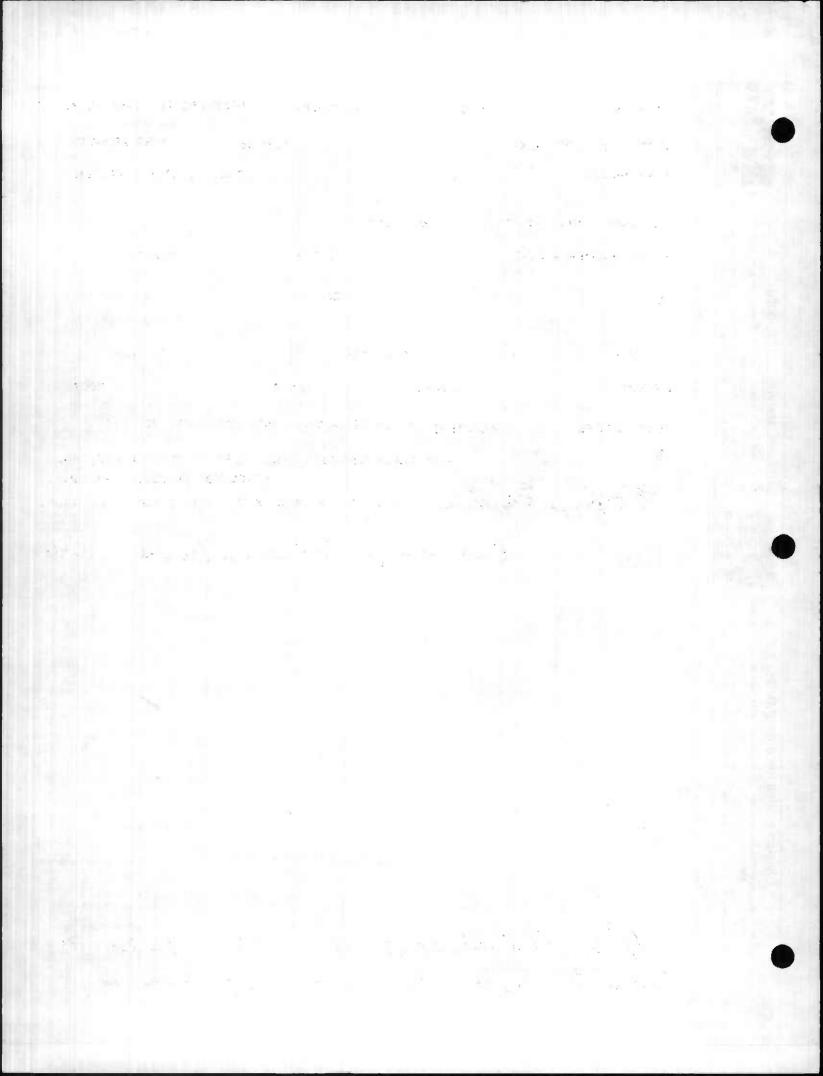


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DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day 10:30AM 1998 28th Mildred Myers Dec 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□ M 200F Months Deys Hours Min. Yrs 214-62-2455 Usuel Residence of Decedent 95 June 20, 1903 Annapolis 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? United States 105 Conduit Street 21401 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, Whita, etc. 11. Meritel Status 1 Yes No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes X ☐ No Specify: white Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker 10 own home 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Sophia Basil Louis Thomas 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 14 Cathedral St. Annapolis, MD 21401 Date Of Disposition (Name of 20c. Location - City or Town, Stete Nancy Ruddell (daughter) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 1X Buriel 2 Cremetion 3 Removel from State Cedar bluff Cemetery 4 □ Donation 5 □ Other (Specify) 12/31/98 Annapolis, Maryland 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signeture of Funeral Service Licencee 147 Duke of Gloucester St. Annapolis, MD 21401 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Cause (Final diseese or condition resulting in deeth) Myocardial Infarct or es e vonsequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? TELYES 2 PAGE

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a Stete

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show trsumatic event, tre Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health end Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Items 23d eny injury or other traumatic event, the Medical Examiner must

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

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Examiner physician and s the burief-trans Physician/Medical 85 950 signed by the a d be detached f ò Completed has

page 2 certificate funeral director, Be Certification: To 24 hours after death. Funeral Director: Af

26. Place of Death (Check only one)

1 Yes 2 0

25. Was case referred to medical examiner? Hospital: 1 Yes 2 LNC 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 6 Could not be determined Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

28d. Describe how Injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 29b. Signature and little of certified

27. Menner of Death

1 Naturel

2 Accident

4 Homicide

3 Sulcide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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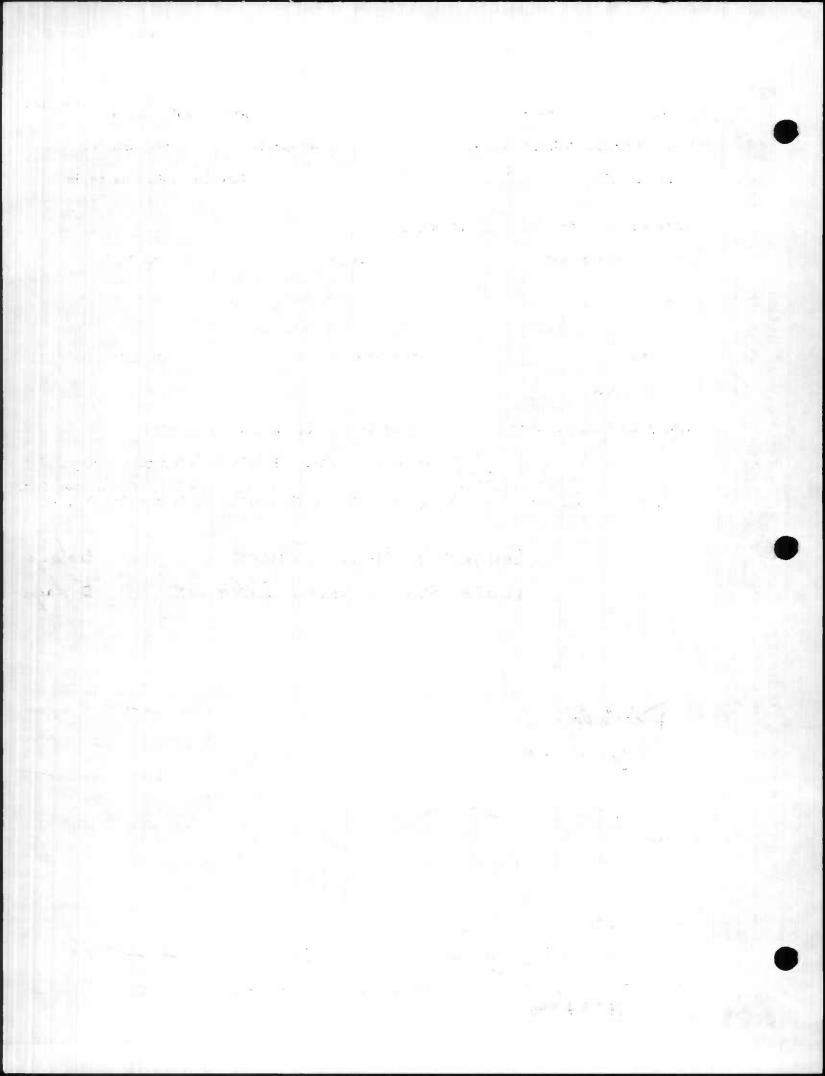
29d. Date signed (Month, Day, Year)

30. Nama and eddres of person who completed aur of deeth (Item 23e) (Type, Print)

Jon B. Lowe, MD, 2007 Tidewater Colony Dr. Suite 2A, Annapolis, MD 21401 32. Phoistrar's Signature

State Registrar

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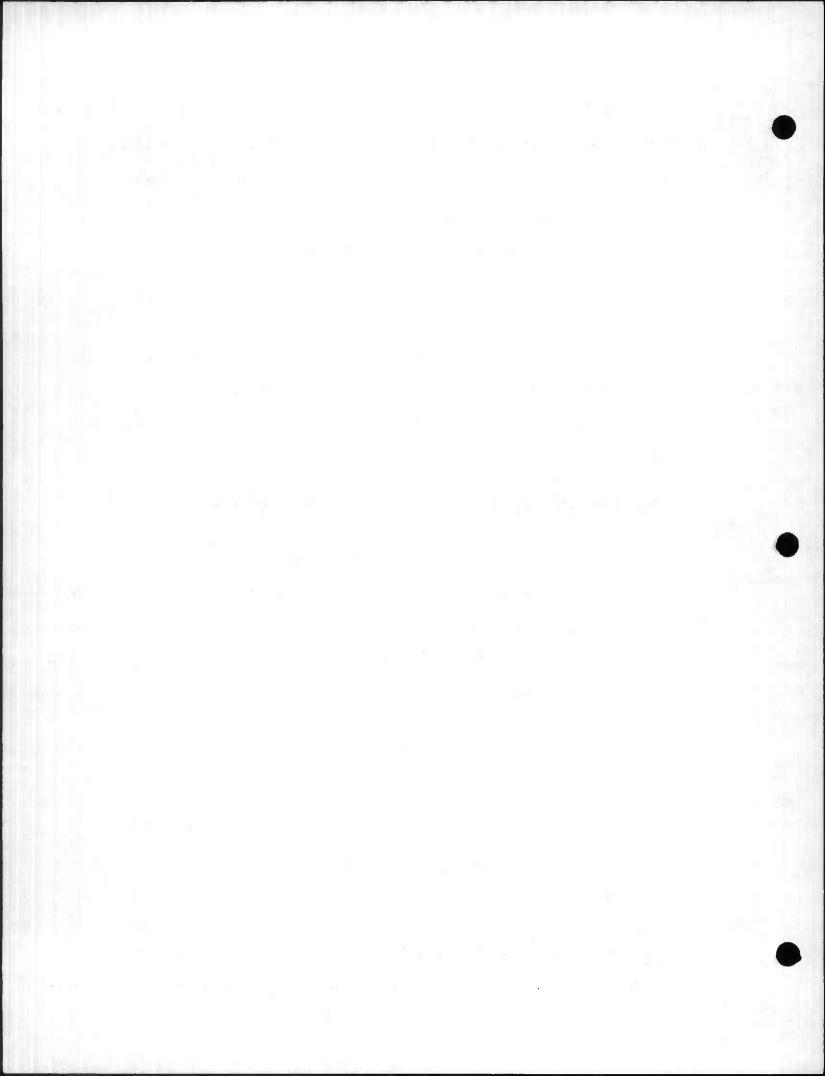


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State of Maryland / Department of Health and Mental Hygiene 0

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5-0020 72 hours efter death with the Maryland	pue *_		Usuel Residence of Decedent  10e. State 10b. County		10c Cit	y. Town or L	ocation							
	Ba-f eho	rai Director	MARYLAND ANNE A	RUNDEL		HIAN	ocation						10d. Inside City Limit	
Maryland 2121	th with th		10e. Street and Number 1208 WHITTINGT	ON DRIV	E		10f. Zip	Code 207	11		10g. Citize	en of What Cor US	intry?	
	be filed within 72 hours after death with the Marylan tial Hygiene.  d other than "naturel", or fiems 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral	11. Maritel Status  1   ↑ Never Merried 2   ↑ Married  3   ↑ Widowed 4   ↑ Divorced	12. Wes Decedent Armed Forces 1  Yes 27 If Yes, Giva Year or Dates:	? No	,S. 13.	Was Deced If Yas, spec 1 ☐ Yes 2		lispenic Orlgin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify:	e, etc.	
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Ba	Depa Impo any I		L. Ogrador of Fundial Convict Electric	-						MORT	ΙΙΔΡΥ	Dλ		
			WM. REESE & SONS MORTUARY, P.A.  821 WEST ST. ANNAPOLIS, MD. 21401  23a. Part, the bend dilease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,  Approximate											
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ă	afte Diri	ent	4 Homicide	building, e	tc. (Specify	1)				City or To	wn, Stete)			
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifiar 1∑ Cartifying Phy (Check only 2 Madical Exam)	elcfan: To the best fner: On the basis of	of my know	wledge, deat	h occurred a	t the tir	ne, date end placa, pinion, death occurr	and due to the	cause(s) a	nd menner as	stated.	
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			Il bellean I	1 the	nn	De	I	0 0	6054		12-	22-199	8	
			30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type,	Print)							
			William P. Jon	es, M.D	. 6	131 S	hadv	Si	de Road	Shad	v Si	de. Mr	20764	
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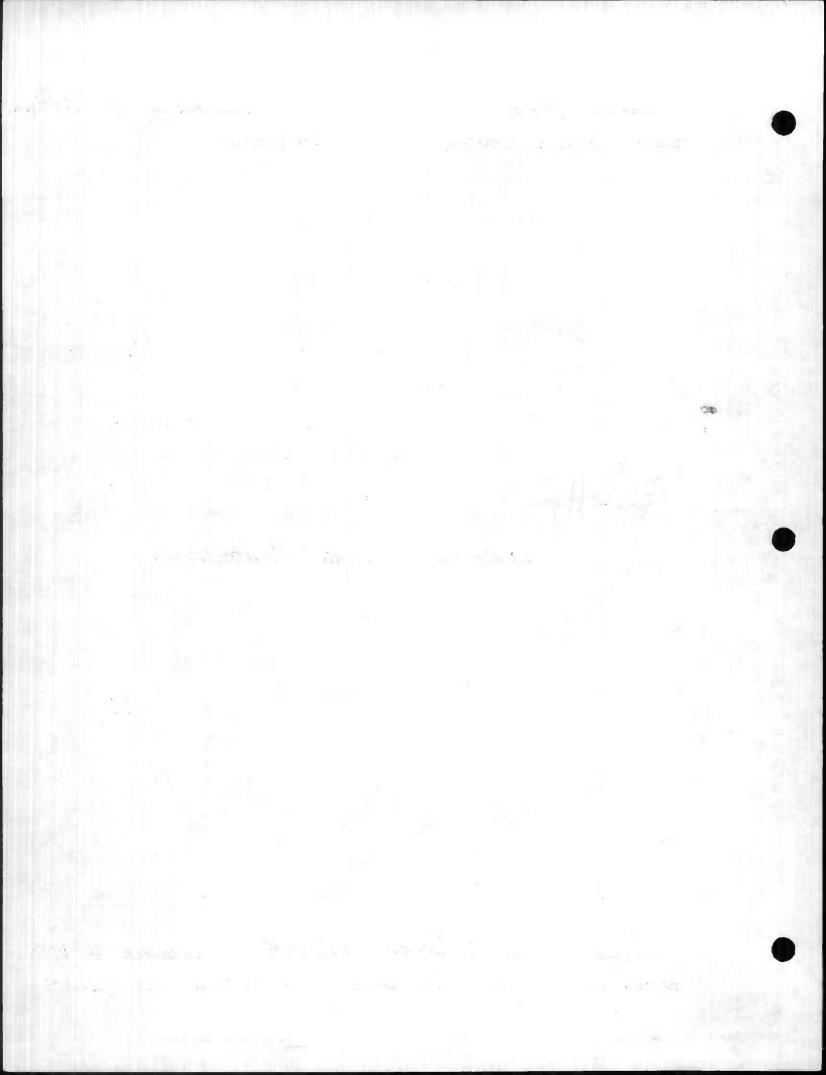


Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day **Physician** Month 1:55pm RESCH 1998 HARLES 2 DECEMBER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER HOSPITAL BALTIMORE HARBOR If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) **Funeral** Days Months 100M 20 F 79 Yrs. Director 217-05-4550 NOV. 17, 1919 MARYLAND Usual Residence of Decedent the Manyland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Nama 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7830 OAKWOOD ROAD 21061 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Agned Forces? 1 €1 Yes 2 □ No 1942 – If Yes, Give Yeer or Detes: 1945 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2K Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiens Important: If from 27 is marked other the eny Injury or other treumetic aware. MASTER ELECTRICIAN ELECTRICAL CONTRACTOR 6 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be CHARLES RESCH, SR. EUNICE MADELENE MICHAELS 19e. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) IRMA M. RESCH (WIFE) 7830 OAKWOOD ROAD, GLEN BURNIE, MARYLAND 21061 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete GLEN HAVEN MEMORIAL PARK 12/28/98 GLEN BURNIE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., ature of F her I Servide Licensee 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 taga 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MESOTHELIOMA Examiner Due to (or as a consequence of): Examiner physician end s the burlel-transit law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): attending I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco usa contributa to the cause of death? PO signed by 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No Records. Aq 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy Deed completion of cause of death? ate hes page 2 1 Yes 2XNo 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(a) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Lunar 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 3001 GANTI SOUTH STREET BALTIMORE HULNASH 31. Date filed (Month. Day, Year) 32. Registrar's Signeture State Registrar DEC 28

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month De c 1815 1998 Margaret Eleanor Swisher 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth
(Moeth, Day, Year)
Jan / 4 / 1911 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 XF 87 Washington DC 578 05 8191 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Annapolis 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Fogel Drive 21403 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽVŽ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Merried 2 Married 1□Yes 2☐No White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond E. Grove Eleanor Erin McKevitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lee Smith (daughter) 103 Fogel Drive/Annapolis MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Metropolitan Crematory 12/29/98 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licegse 22 Name and Address of Facility
Advent Funeral & Cremation Services > Melanie 9 Annapolis MD 21401 23a, Part1. Enter the disease, or complications that caused the shock, or heert failure. List only one cause on each line. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No 002031 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how tnjury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work?

Physician /Medical Examine Examiner

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Box 68760

P.O.

Division of Vital Records.

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Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homleide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title ofcertifier

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License numbe

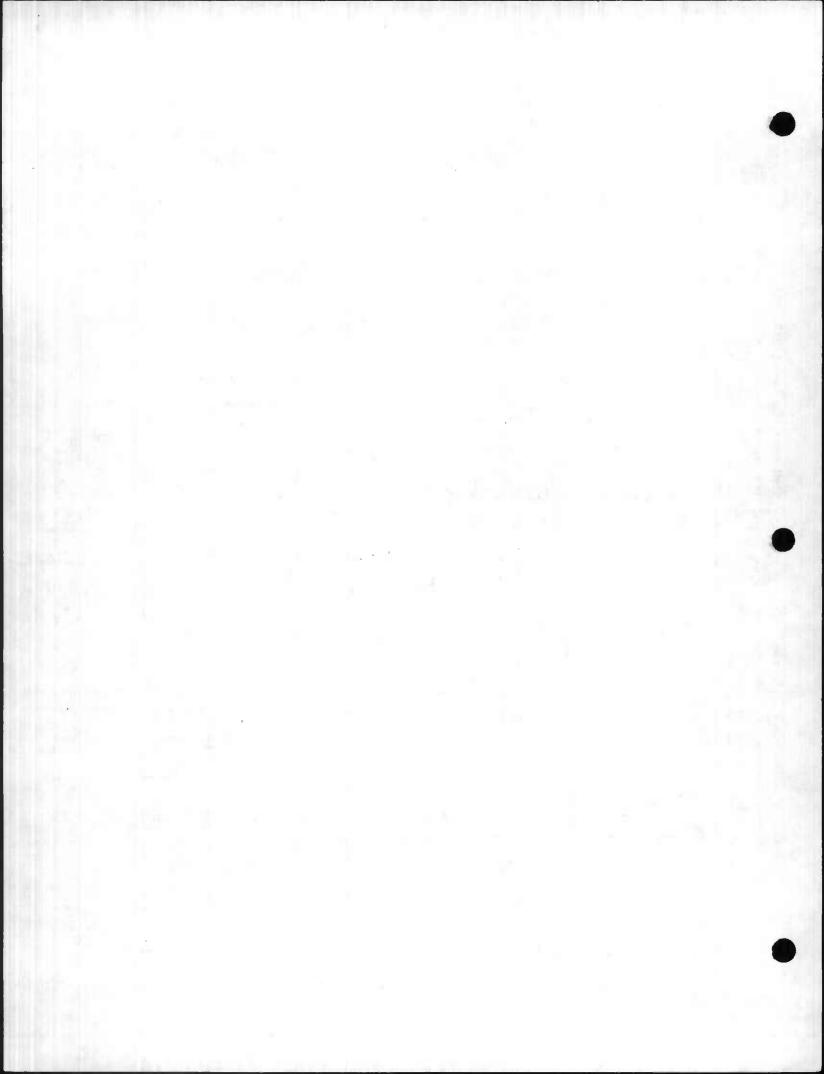
29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) Mr

160 Admiral Column

State Registrar

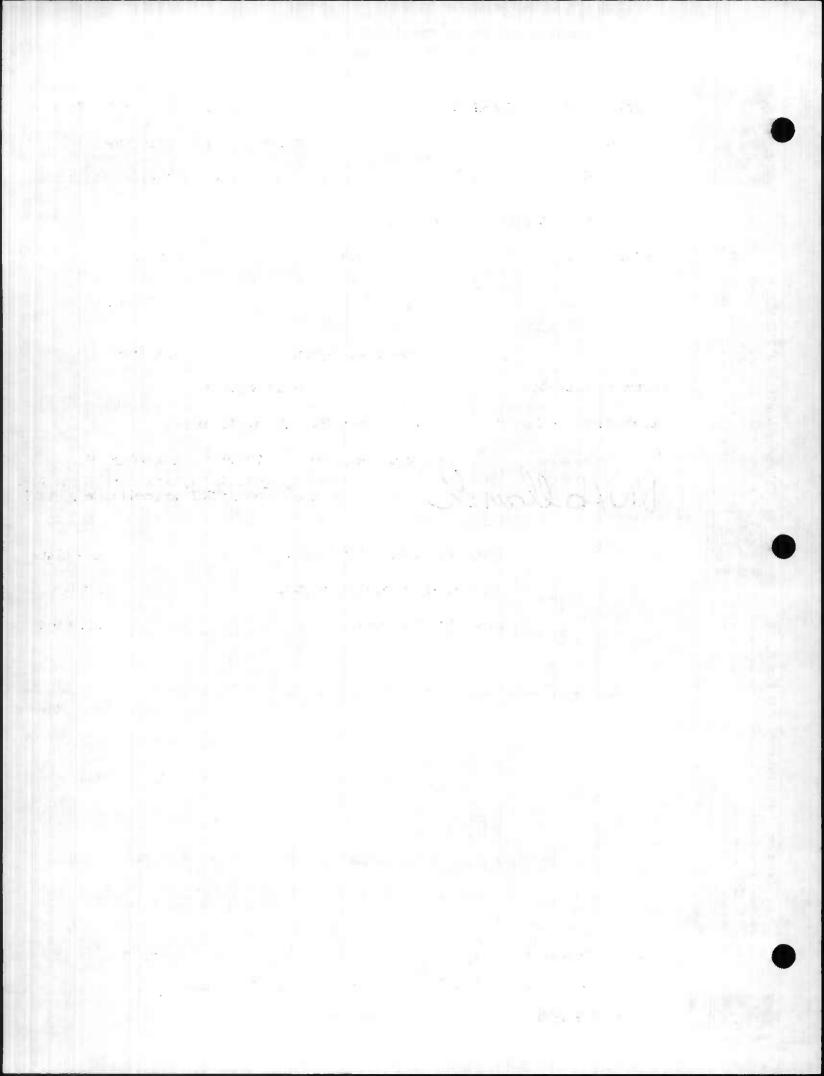
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	and was		10e. Stete	10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	Mary Infled	ctor	Md.	Anne Ar	undel	Lo	othian							1 □ Yes an No
	ath with th	Funeral Director	10e. Street and Nur 631 Tet						0711			U.S.A.		Bereit
Maryland 21215-0020	within 72 hours after death with the Maryland ene. then "netural", or frems 23s or 28s-f show he Medical Examiner must be nouthed as	Completed by Fune	11. Meritai Status  1  Never Merri  3  Widowed	ied 2 Married 4 Divorced	12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	?		1□ Yes	2 <b>X</b> ) No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	21.		ck, White,	
2-0	72 h	etec	(Spec	15. Decedent's E	ducation ade completed)		16a. Deced (Give	dent's Usua kind of wo	ai Occup	petion during most of work d)	ing	16b. Kind of Bu	usinass/Ind	dustry
121	within ene.	E E	Elementery/Seco		College (1-4or	5+)						TI C N		
d 2	D S S	ပိ	17. Father's Name	(First Middle Las	1		Pulci	nasin	y Ac	18. Mother's Nam	e (First Middle.	U.S. N		
an	Mental Merked of marked of marked or	2 Be		E. Rutle						Nora Con			,	
2	and Menta and Menta is marked aumatic av	0	19a. Informant's Na				19b. Mailir	ng Addrass	(Street	and Number or Rur		r. City or Town.	State, Zio	(Code)
			Ann Naz		Sister)					. Malden,		148		
Baltimore,	permit. Pages 1 and 2 should Department of Haaith and Mer Important: If frem 27 is marks eny Injury or other traumatic once.			position	Removal from State		lace of Dispo emetery, cren .lcrest	sition (Nar	ne of other pla	се)	Date 2/29/98	20c. Location -		
altir	Department Important: any Injury	1	21. Signature of Fu		-	0								Home Inc.
m	8858	1	>//N	1401	laure	义	/ 14	7 Dul	ke c	of Glouces	ter St.	Annapo	lis,	Md. 21401
	Physician		23a. Part1. Enter to shock, or hea	he diseese, or con rt failure. List only	plicetions that cause one cause on each	d the deeth ine.	n. Do not ent	er the mod	le of dyi	ng, such es cardiac	or respiretory en	rest,	!	Approximate interval Between Onset end Deeth
П	/Medicai Examiner		tmmediata Causa ( disease or conditio		Acut	е Мус	cardia	al In	farc	tion			I	Immediate
		9	resulting in death)		New		r as a consec							
	d ansit	E	Convention lint on		b		en dep			liabetes			- 12	years
68760,	ficate be executed physician and as the burial-transit	edical Examiner	Sequentially list co- if any, leading to in- cause. Enter Unde Cause (Disease or that initiated evants	mediata ortying injury	с. Нуре	rchol	estero	olemia		11/4		11/3	I	ifetime
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Box	death cer	Physician/N	Part tl. Other signif	cant conditions	contributing to death	out not resu	ulting in the u	nderlying c	ause gi	ven in Part i.	23b. Dld to	obacco use co	ntribute to	o the cause of death?
P.0.	that the ed by the detache										101	/ee 2□ No	3 □ Pro	bably 400 Unknown
Records,	requires	Completed by			7				3		24a. Was a perfor	an autopsy med?	ev	ara eutopsy findings allebie prior to impletion of cause death?
	The law	E									1 U Y	es 210 No	1[	☐ Yes 2☐ No
Vita	ysician: The	ne ne	25. Wes case refer examiner?	red to medical						26. Place of Deel	th (Check only o	ne)		
of <	G o G	0	1 Yes 2 X	No	Hospital: 1   inpat	ient 2	ER/Outpatier	nt 3 DC	DA Ot	her: 4 Nursing Ho	ome 5 Resid	ence 6 □Oth	er (Specil	<b>'</b> ሃ)
iono	Attending Pr r daath. ector: Affar th by the funera	27. Manner of Death 1 Natural 2									28d. Describe h	ow Injury occur	red	
Division	s after da il Directo od in by th									28f. Location (S City or Tow		ber or Rura	al Route Number,	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, date and manner stated.												
	within To th										29d. Date signe	d (Month,	Day, Year)	
			181	). fulle	El H	0		I	DC 1	3077		Dec. 2	8, 19	98
					completed cause of kelman, M.				vani	a Ave. NW	Washin	gton D.	C. 20	0037
	Stat Registra		31. Date filed (Mont	th, Day, Year) C 2 9 199	32 Regist	rer's Signa		400						

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Deeth 3. Time of Death Month homas 4a. Fecility Name (If not Institution, give street end number 4h City Town or Location of Deeth 4c. County of Death gen. DITAL Arundel 1105, Dete of Birth (Month, Dey, NNA if Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number 9. Birthplace (State or Foreign Deys 214-70-1614 Hours 1X M 2 ☐ F 41 Washington D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1645 Bald Eagle Road 21012 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) 5+ Software Engineer Computer Science 12 +17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Fred Shaffer Molly Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Janine Shaffer, wife 1645 Bald Eagle Road Arnold, MD 21012 20a. Method of Disposition Dec. 30 20c. Location - City or Town, State Asbury United Methodist Church Cemetery 1 Burial 2 Cremation 3 Removal from State 1998 Arnold, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final rrhythmia disease or condition resulting in death) MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work?

**Physician** /Medical Examiner

that the death certificate be executed

Box 68760

P.O.

Records.

Division of Vital or Attending Physician:

daath.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

6

items 23a

"naturel", or

permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiane. Important: If flem 27 is merked other than any injury or other traumetic event

the

72 hours efter

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

by

Completed

Examiner Physician/Medical by Completed Be

physician end s the burial-transit attending p 980 ed by the s signed b peen page 2 certificate Certification: To funeral After after death Director: / d in by the i To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

25. Was case referred to medical 1 Yes 2 No 27. Manner of Deeth 5 Pending investigation 1 Naturel 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) end manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

32. Registrar's Signature

29d. Dete signed (Month, Day, Year)

use of death (Item 23e) (Type, Print) 30. Name and address of person who completed ca Hipm DNOS

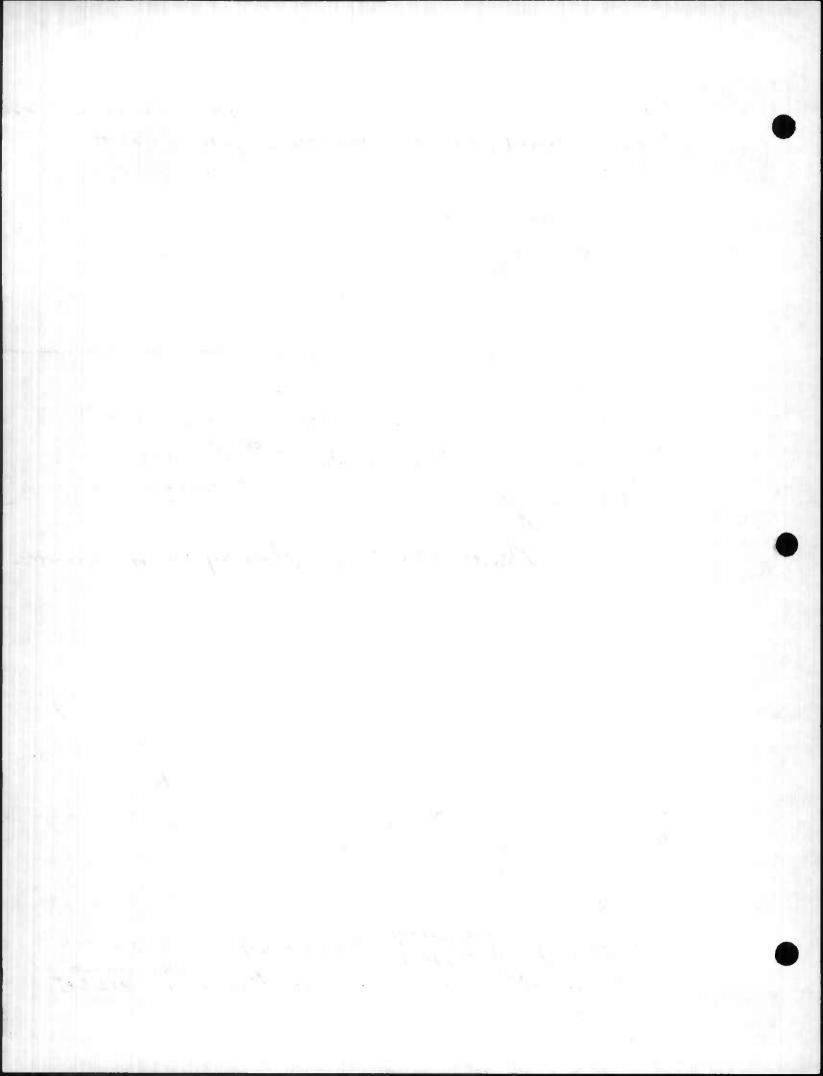
695 America 21035

State Registrar

Medical

31. Date filed (Month, Day, Year)

DEC 2 9 1998

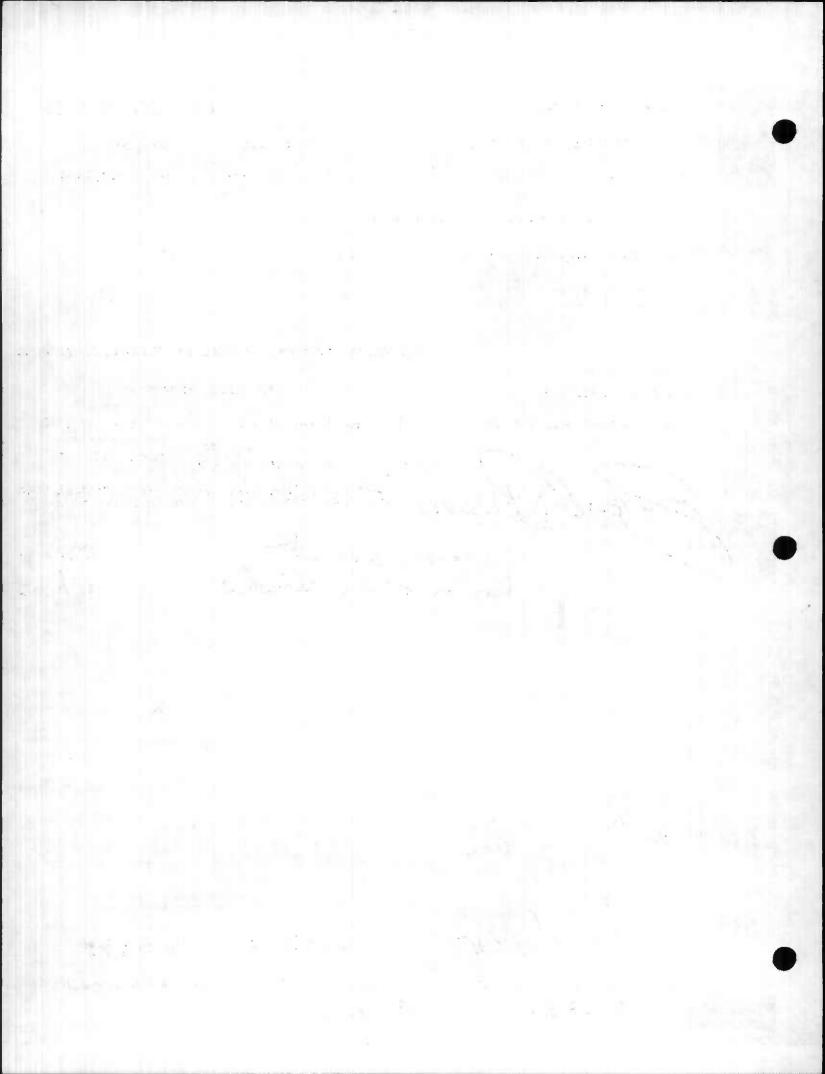


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				C	eruncate of	Deam	R	eg. No.				
	/sician	1. Decedent's Name (First, Middle, John L. Saveles			15		2. Dete of Dea Month	Day 2	Year 98	3. Time of Death		
	ledical	4a Facitity Name (If not institution,	giva street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	19,00		
EX	aminer	Anne Arundel M		210		Annanal						
- 1				In yrs. lest birthde	If Under 1 Yaa	Annapol: r   If Undar 24 Hrs.			Arur 9. Birtho			
Fund Direct		199-30-3067	128M 2 F	57 Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Day Aug 28,			lece (Stete or Foreign stry)		
Direc	,101	Usuei Residence of Decedent					Aug Zo,	1941	Mai	yland		
and	100	10a. Stata 10b. County	1	Oc. City, Town or	Location				10	0d. Instde City Limits		
effer death with the Maryland or items 23s or 28s-f show	eral Director	MD Anne A	rundel	Annapo						1 ☐ Yas 2% No		
5 5	a ic	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhet Coun	fry?		
£ ₩	ia ia	1288 Cape Saint	Claire Road		21401			USA				
9 5	9 5	11. Marital Status	12. Wes Decedent Eve August Forces?	ar in U,S. 1	3. Was Decedent of	Hispanic Origin? (Sp ben, Mexican, Puart	pecify Yes or No-		e - Amaric			
5-0020 72 hours efter natural*, or its	by Fun	1 ☐ Navar Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:	961 <u>-</u> 1965	1□Yes 2Ã No		, , , , , , , , , , , , , , , , , , , ,	Specify	V.73. 1			
21215-0020 d within 72 hours ef piene. r than "natural", or		15. Decedent's	Education		cedent's Usuat Occu	upation		16b. Kind of Bu	siness/inc	dustry		
0 2 2	Completed	(Specify only highest	grade completed)	(G	iva kind of work done a. DO NOT use retire	upation e during most of work ed)	king					
within one.	ome	Etementary/Secondary (0-12)	College (1-4or 5+)					an Fede	eral	Government		
		17. Fethar's Neme (First, Middla, Li	nst)			18. Mother's Nen	ne (First, Middle,	Meiden Sumem	(e)			
Vian Wental	e e											
	To To	John M. Saveles		T 401 04	N 444 (0)	1	t I. He			0.41		
Aar 2 sh and is m	5	19e. Informent's Name/Relationshi				et end Number or Ru						
2 2 2	other	Lois A. Saveles	kı / Wire			Saint Clai	T			MD 21401		
2 2 2	50	20e. Method of Disposition  1 ☑ Burial 2 ☐ Cramation 3	□ Pamoual famous	20b. Placa of Dis cemetery, of	sposition (Nama of cremetory or other pl	eca)	Dec. 28	20c. Location -				
Pages nent of mt: 1f ite		4 Donation 5 DOther (Spe		Marylax	d Veterar	s Cemeter		Crown	svil.	le, MD		
Baltimore permit. Pages 1 e Department of He Important: If item	eny injury	21. Signeture of Funeral Service Li	Cogispo /		22. Name end Add							
n aae	Sud (	James 6	1 DS		Barranco	& Sons I	A. Seve	erna Pa	rk Fu	neral Home		
_	-	MIR)	bisc	mos					Park,	MD 21146		
		23a. Pert1. Entar the disease, or or shock, or pert feilure. List or	om lic as fat caused the	e death. Do not	antar tha moda of dy	/ing, such es cardled	or respiratory an	est,		Approximete Intervat Between Onsat and Deeth		
Physic	_		V .	n.		A						
/Medi		Implete Cause (Finel ase or condition	Croso	lioc	Otrs	3			1	20 mins		
Exam		resulting in death)	Di	ue to (or es e con	sequence of):	A	n			20 mins		
70	Examiner		Bro	in s	tom	Derod	be.			48 horas		
certificate be executed ding physicien and	aus Laus	Sequentially list conditions.	b. Du	ue to (or es e con	sequence of):							
, 8 6 .		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury										
os / ou,	use as the bu	that initiated events	C	e to (or as a cons	sequence of):				1			
D licat	edic edic	resulting in death) Last	00	10 10 (01 43 4 001)	sequence ory.				i			
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law requires that the as been signed by th	a A							1	_			
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0 2 8	suc suc						perior		CO	mplation of causa death?		
He law	Comp						4 D V	es 20 No		111-00		
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OT VITAL Physician: The	To Be	25. Wes case referred to medical exeminer?	Hospitel:		10	Wher:	ith (Check only or					
Physic this of	20 1	1 Yes 2 No	Inpatient		Herit 3D DON	4 🗆 Mulaling H	ome 5 Resid			y)		
DIVISION OF VITAL RECORDS, to a Attending Physician: The law requires the after death.  Director: After this certificate has been signed.	on:	27. Menner of Death  1 Neture 5 □ Pending	28a. Date of Injury (Month, Dey Y	(ear) 28b. Time Injui		ury et ork?	28d. Describe h	ow injury occur	Der			
VISION Attending or death.	ati	2 ☐ Accident Investige		☐ Yes 2 ☐ No								
DIVISIO	III ON	determin	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At homa, farm, straet, fectory, office building, etc. (Specify)						er or Rura	al Route Number,		
בַּבְּבֶּבְ	Certification:		bunding, etc. (		City or Tow	/						
Hospital 24 hours Funeral	in in											
Hospital 24 hours Funeral	Medical Certification			xeminetion end/or								
To the within 2 To the	M M	29b. Signatura and fittle of cartifier		nse number		9d. Date signe	d (Month.	Day, Year)				
735	ŏ	10/10/10	c. License number $\frac{29d}{\sqrt{2}}$ Date signed $\frac{29d}{\sqrt{2}}$									
		18/00/12/12/19							2.1	0.		
		30. Neme end eddress of person w										
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		04 D-1-10-1 04-11 D-11		- C!								

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Jarrett Thomas Lemuel December 31, 1998 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDER CARE LA PLATA CHARLES 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1₽M 2□ F Deys Yes. 217-18-5769 76 JULY 27, 1922 MARYLAND Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tayes 2 □ No MARYT AND CHARLES **NEWBURG** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? P.O. BOX 25 20664 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Maπied 2 ☑ Married 1 ☐ Yes 2 ØNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry CHARLES COUNTY BOARD Eiementary/Secondery (0-12) College (1-4or 5+) 7th OF EDUCATION BUILDING SERVICE WORKER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) JARRIETT THOMAS MYRTLE WHEELER THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MARY THOMAS / WIFE P.O. BOX 25 NEWBURG, MARYLAND 20664 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State SHILOH CHURCH CEMETERY 1/5/99 NEWBURG, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JESTIA E. THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Respuret moulh Immediete Cause (Finel diseese or condition resulting in deeth)

Physician /Medical Examiner

signed by the at d be deteched for

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filled in by

i or Attending Physicien: efter death. Director: After this certifica

24 hours e Hospital

To the Hosp within 24 ho To the Fune completely f

Department of important: If any injury or once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

ns 23a or 28a-f show

Herns 2

8

"natural".

lal Hygiene.

. Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth lury or other traumatic even

trsumatic event, the Medical Examiner

Director

Funeral

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Completed

Be

the Maryland

death with

filed within 72 hours after

21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Division of Vital Records.

Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest the burial-tran physician Physician/Medicai

		Due to for as e consequence of.	0
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	b	Due to (or es e consequenca of):	
that initiated events resulting in deeth) Lest	С.	Due to (or as a consequence of):	
	d		
Pert II. Other significant condition	ns contributing t	o death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

P atrial Fifullation 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? TLIYES 24 TNO ITTYRS 21 INO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ursing Home 5 Residence 6 Other (Specify) 27. Menn 1 Deeth Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 99 0002/031

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Michael A. Leatherwood, MD 700 Olde Line Center Waldorf, Maryland 31. Dete filed (Month, Dey, Year)

State Registrar

JAN 04

32. Registrar's Signeture

A PART TANAL

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# Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Cel	rtificate of	Death		Reg. No.	
Shi.i.a.	1. Decedent's Name (First, Mid	die, Last)					2. Date of De Month		3. Time of Death
Physician /Medical	Erra Viola Way	d					Dec.	27th 1	
Examiner			umber)			4b. City, Town, or	Location of Deat		
	610 Americana		1			Annapolis	1 2 2 1 12	Anne A	
Funeral	5. Sociel Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	Yrs.	Months Day:		8. Dete of Bir (Month, De	y, Year)	Birthplaca (Stete or Foreign Country)
Director	214-05-1659 Usuel Residence of Decedent		86	110.			May 26	th 1912	Maryland
Hygiene.  Whyser than "natural", or frame 23a or 28a-f ahow art, the Medical Examiner must be notified at a Completed by Funeral Director	10a. Stete 10b. Coun	ty	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
in and Mentel hygene. 7 is marked other than "natural", or itama 23a or 28a-f ahow traumatic avant, the Medical Examiner must be notified at To Be Completed by Funeral Director	Maryland Anne	Amunda1	Ann	polis					1 X Yes 2 □ No
28e	10e. Street and Number	Ardider	Ailli	polla	10f. Zip Code			10g. Citizen of Wh	eat Country?
Se di	610 Americana	Drive			21403			United S	tates
r frams 23a or 28a-fa niner must be notified Funeral Director	11. Maritel Status	12, Was De	cedent Ever in U	,S. 13.		Hispanic Origin? (S ben, Mexican, Puer	pecify Yes or No		- American Indian,
F. F.		Armed F arried 1 Yes	2 X No live				o Hican, etc.)		White, etc.
by by		ed Year or	ive Dates:		1 ☐ Yes 2 ☑ No	o Specify:		Specify:	White
in be	15. Decede	ent's Education	n	16a. Dece	dent's Usual Occ	upation e during most of wo	rkina	16b. Kind of Bus	ness/Industry
old old	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use retir	red)	All 19		
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	William G. Phe	ilps Jr. /			-	Shore Ac			Maryland 2101
If Ram 27 or other tr	20a. Method of Disposition 1 □ Burlal 2 ☑ Cremation	2 DRomovei from		Place of Dispo cemetery, crea	netory or other p	lece)	Date	20c. Location - C	ity or Town, State
int: I	4 Donation 5 Other		1 Men	Propoli	tan Cre	matory	12/29/9	8 Alexand	ria, VA.
Department of Heal important: If item 2 any injury or other page.	1. Signature of Funerel Service	e Licensee		/2:	2. Name and Add	ress of Fecility	1 1/ 5	1 1	neral Home, In
hysician /Medical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li  Immediate Ceuse (Final disease or condition resulting in death)	or complications the strong one cause as a	an	th. Do not ent	nè	ying, such as cardia	c or respiratory a	irrest,	Approximate Interval Between Onset and Death
te has been signed by the attending physician end page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner		(	coro	nan	an	, teny	Des	lare	
physician end s the burial-transit	Sequentially list conditions,	0.	Due to (	or as a consec	quenca of):				
unal K	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury	)							
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signed by the attending p d be detached for use as d by Physician/Mee	Pert II. Other eignificant condi	tions contributing to	death but not res	uiting in the u	nderlying cause	given in Pert I.	23b. Dld	tobacco use cont	ribute to the cause of death?
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person who completed cause of death (Item 23a) (Type, Print)

M. A. 2000 Pefense Highway Coston, Md.

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To To

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAIllIW Willelee, 7:02am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign, Months | Days | Hours | Min. | Feb. 23, 1928 | North Carolina 7. Age (In yrs. last birthday)
70 Yrs. 5. Social Security Number 6. Sex **Funeral** Months 100 M 20 F 420-32-4290 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 'natural', or items 23s or 28s-f shordest Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes ZKINo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 417 Ben Oaks Drive East 21146 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or he any injury or other treumatic event, the Medical Example. 1. Yes 2 No If Yes, Give 1 Yeer or Dates: 1 Never Merried 2 Merried specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Utilities Engineer 12+ Whiskey Distillers 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be William V. Wheeler, Sr. Esther Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Wheeler / Wife 417 Ben Oaks Drive East, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dec. 29 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 1998 MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home Cell 495 Gov. Ritchie Hwy. Severna Park, MD 21146 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Pert1. Enter the disease, or complications that shock, or heart feilure. List only one cause of Approximete Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Myscardial Interi Examiner Due to (or as a consequence of): Examiner cord Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial : 5 Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 25 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No death. NIA 2 Accident 24 hours after deat Funerel Director: 6 ☐ Could not be determined 3 SuicIde 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) within 2

State Registrar

29b. Signeture end title of pertitie

30. Name and agtires

31. Date filed Month Dey,

DEC 2 9 1998

**DHMH 16 Rev 6/95** 

death

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

of Vital Records.

Division

or Attending Physician:

Hospital

To the

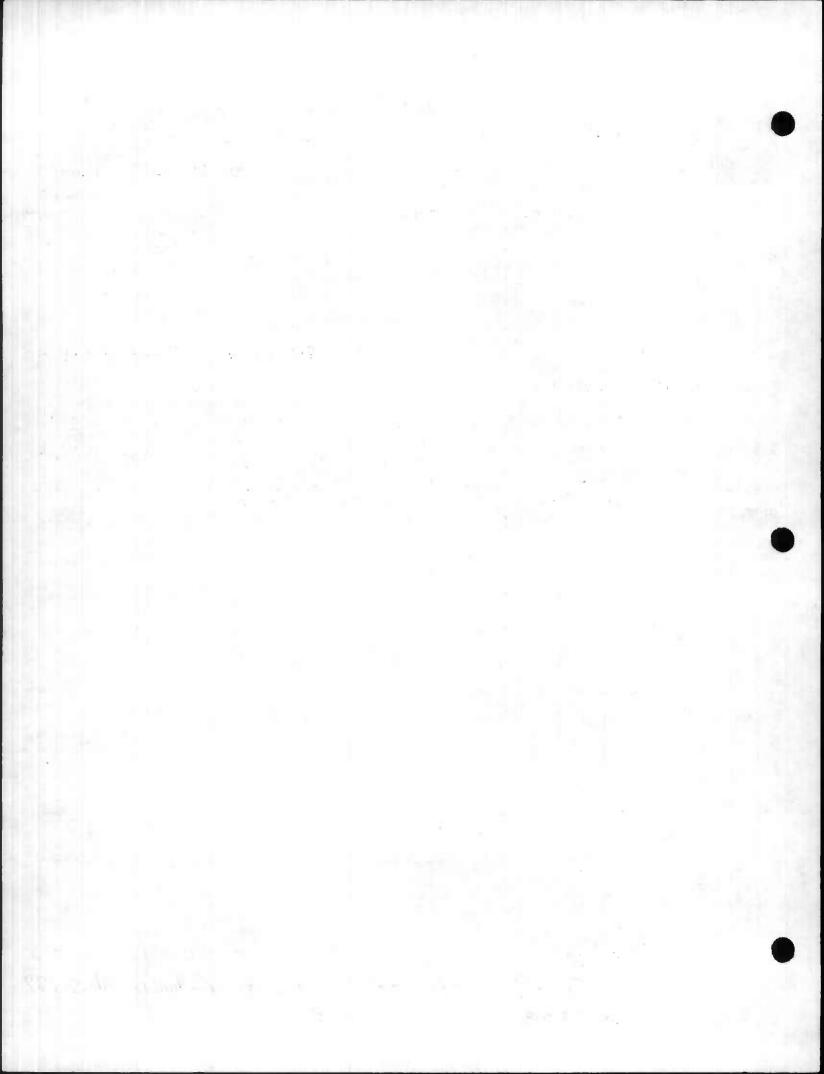
who completed cause of death (ttem 23a) (Type, Print)

SpCr/V, //I)
32. Registrar's Signature

29c. License number

29d. Dete signed (Month, Day, Year)

600 N. Wolfe Str Baltimore, MD 21287



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene R Certificate of Death Amend #26 12/29/98 Sm AACO Health 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Elizabeth Warrington 21, 1998 Mary December 11:15am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street and number) Examiner 900 Bestgate Road, Suite 300 Anne Arundel Annapolis If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Birthplace (Stete or Foreign Country) 8. Sex 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 2∰F Months Deys 73 197-18-3289 March 1,1925 Director Pennsylvania Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10e State 10b County 7 is marked other than "natural", or items 23s or 28a-f shov traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No MD Anne Arundel Arnold Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 352 Buena Vista Avenue 21012 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marltal Status Bleck White etc. 1 Never Married 2 Merried White 1 ☐ Yes 2 No Specify: 70 3 d Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk. Pharmacy 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Elizabeth McGurk John Kearns 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Ernest Oehm / son 352 Buena Vista Avenue, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Dec 28 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department o Important: If eny Injury or Meadowridge Memorial Park Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 1998 21 Sto a ure of Pherel Strville Licent 22. Name end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intarval Batween Onset and Deeth **Physician** Lung cancer +mos. /Medical Immediata Causa (Finel disease or condition ulting in death) Examiner Due to (or es a consequance of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseasa or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 2□ No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Doctor's 10 1 ☐ Yes 2 No 2 Proutpatient 3 DOA 1 Inpatient 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred Office 28c. Injury at Work? 1 Natural 2 Accidant 1 ☐ Yas 2 ☐ No

and **bunial-trar** The law requires that the death certificate be exec P.O. Box 68760, physician the 88 ed by the a detached f signed by t Division of Vital Records, peeu has page 2 cartificate Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this carifica director, illed in by Medical

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after of the of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or item

other

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altimore, Maryland 21215-0020

28a-f show

Certification:

5 Pending investigation

6 Could not be determined

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Phyeician: To the best of my knowledga, daeth occurred et the time, date and place, and dua to the ceuse(s) and menner as stated.

2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 38

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print) Straut selouicy, mio.

900 Bestgate Annapolis, Und. 21401

State Registrar 31. Dete filed (Month, Day, Year)

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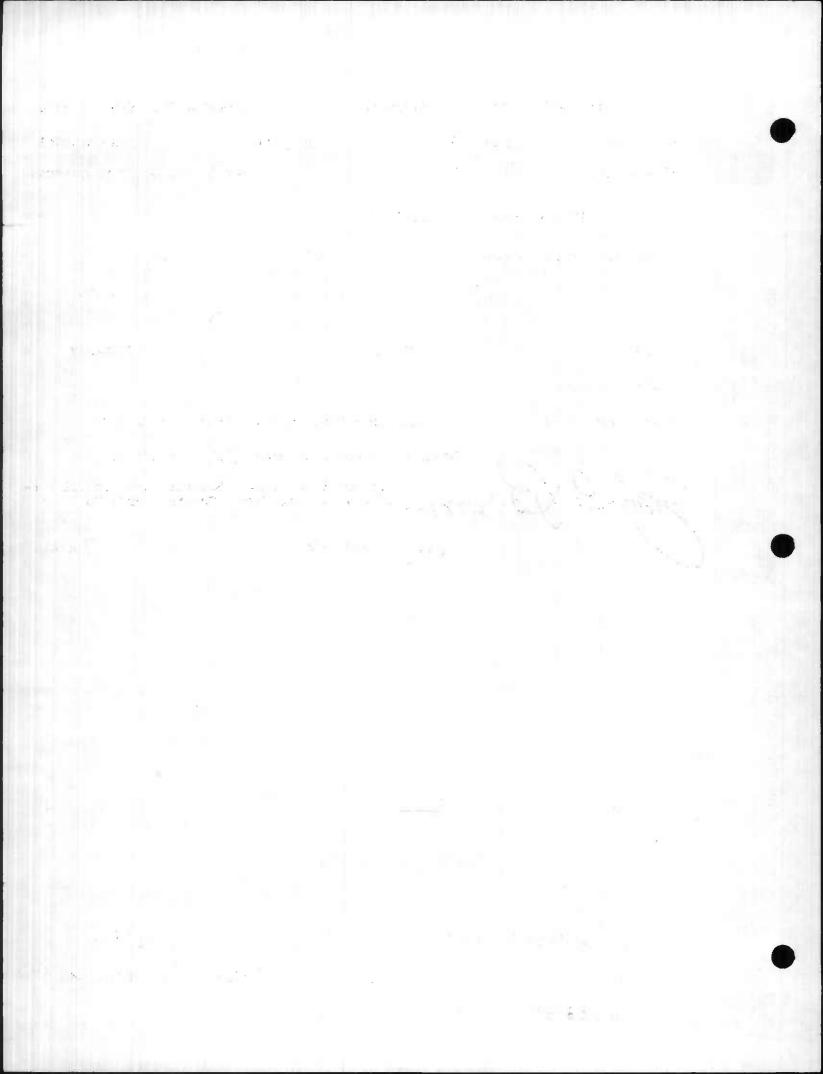
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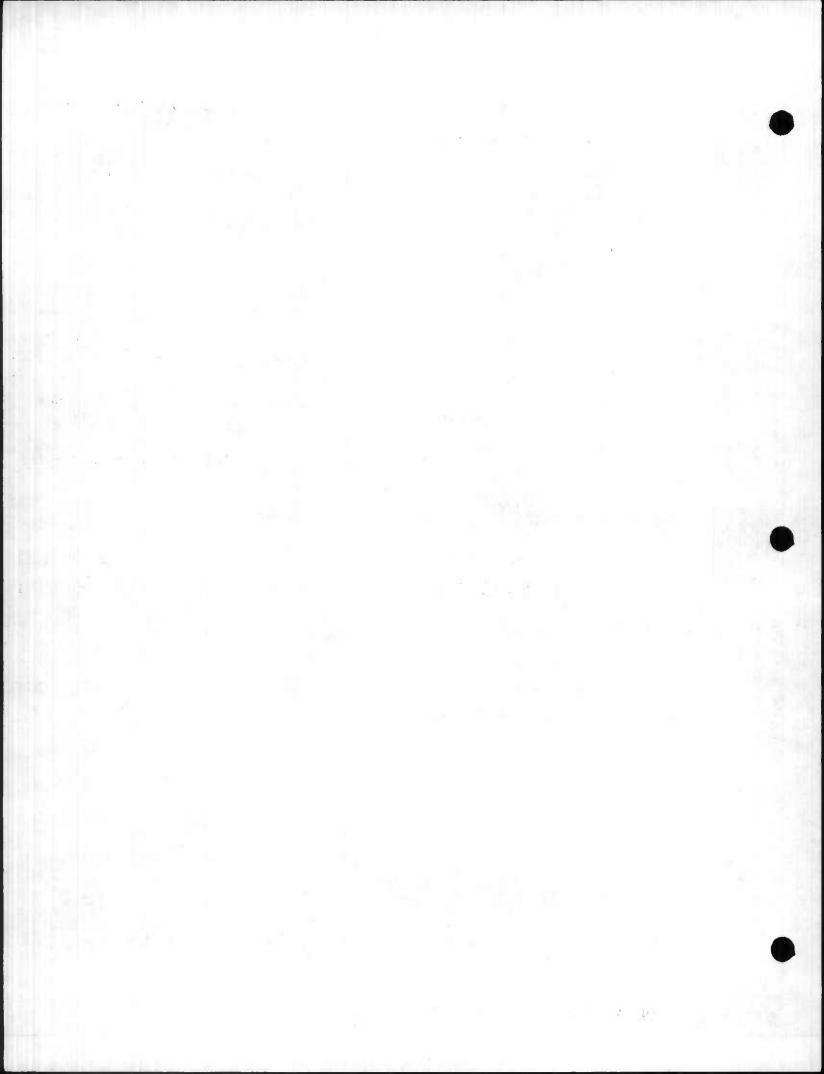


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	Cartificate of Death			

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100	/Medic Examin		4a Facility Nama (If not institution			-				4b. City, To	own, or L	ocation of Deat		nty of Death		
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	ter dea	Funeral	11. Marital Status	1	2. Was Dec	edent Evar in	U,S.	13. Was D	ecedent of I	Hispanic Or	igin? (Sp	pecify Yas or No Rican, atc.)	- 14. R	ace - Amari		n,
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	10		30. Nama and address of person	/ P	nplated cau	sa of death (II	tem 23a) (	Type, Print)	TIN	m	0	204	7			
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11-51	Sta Registr		DEC 3 0 199		Send	me	19.	don	Uh)							

DHMH 16 Ray 6/95



permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, is a Medical Examinar must be notified at Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

10a. Stete

**Funeral** 

Director

Physician /Medical Examine

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the Iuneal director, page 2 should be detached for use as the bunial-transit

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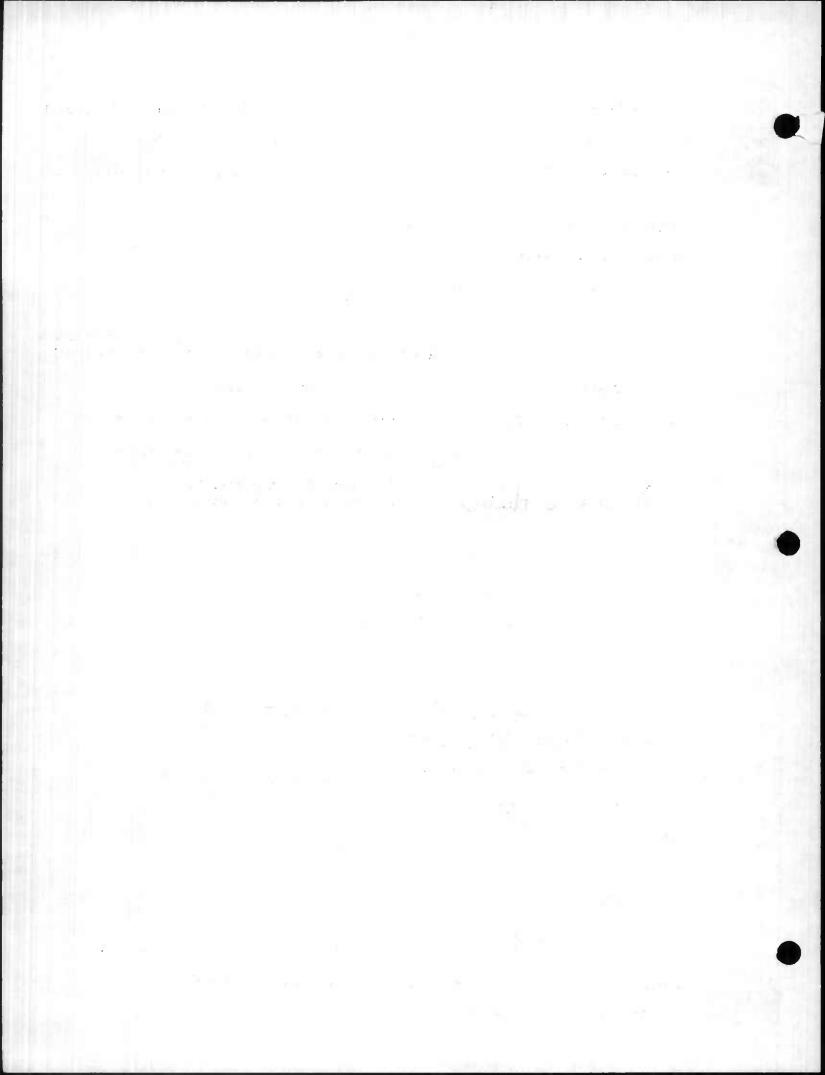
State Registrar

31. Data filed (Month, Day, Year)

JAN 0 4 1999

ctor	Maryland Cecil	E	1kton						1 ☐ Yes 2 ☑ No
Directo	10e. Street end Numbar			10f. Zip Code			10g. Citizen of \	Whet Country	?
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by Funeral	11. Maritel Status  1 Never Marriad 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Evar In Armed Forcas? 1 ☑ Yes 2 ☐ No WW If Yes, Give Yeer or Datas:		3. Wes Decedent of H If Yes, specify Cuba 1 ☐ Yas 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or Note Rican, etc.)	5 Specify	e - American ck, White, etc : Whi	
ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	cedent's Usuel Occup	etion	rkina	16b. Kind of B	usiness/Indus	itry
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)		ve kind of work dona . DO NOT use retired y Equipmen			Wharf - Pile Dr		uilders- Local
To Be C	17. Fether's Neme (First, Middle, Last) Stephen Blendy					me (First, Middle	, Maiden Sumen	na)	
	19a. Informant's Name/Relationship (7) Tillie A. Blendy/			iling Addrass (Street Norman All					
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Sa	Plece of Dis comatery, co int Ro emeter	position (Nema of remetory or other plet OSE Of Lim	a Jan	Data uary 2,	20c. Location - Chesape Marylan	ake Ci	
	21. Signature of Funeral Service Licans		1	22. Neme and Addre Hicks Home 103 West S		erals,	P.A.		nd 21921
vMedical Examiner	23a. Part1. Enter the disease, or complishock, or heert feilure. List only of limmediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to Immadiate cause. Enter Underlying Ceuse Disease or injury that initiated events resulting in death) Last	Due to  Due to  CHF a	(or es e cons	equenca of):	g, such es cardiad	c or respiretory e	prest,	Int	pproximeta tervet Batween nset and Deeth
Completed by Physician/Medical	Pert II. Other eignificant conditions con  Ts Premic Car	dismuserat	A.	1.1+6	en in Part I. Zij Fracti	ne 1×	<b>Y••</b> 2□ No	3 Probab	e cause of death
omplete	Hypernation Acute and Che	mickenal F	allu	e Atti	2001	perfe	of death?		ble prior to letion of cause lth?
o Be C	25. Was case referred to medical exeminer?  1 Yes 2 No	lospitai:	TED/Outcoti	Oth Oth		oth (Check only			es 2 No
fication: T	1 Naturel 5 Panding 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)	tient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidenca 8 Other (S. jury Year)  28b. Time of Injury et Work? 1 Yes 2 No  28f. Location (Street end Number or				ed	oute Number	
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Me	29b. Signeture and title of cartifier	=W		29c. License	onumber		29d. Dete signed	Month, Day	
	30. Name and address of person who co Robert Denitzio M			h Street,	Elkton,	Marylan			Barrier and the second

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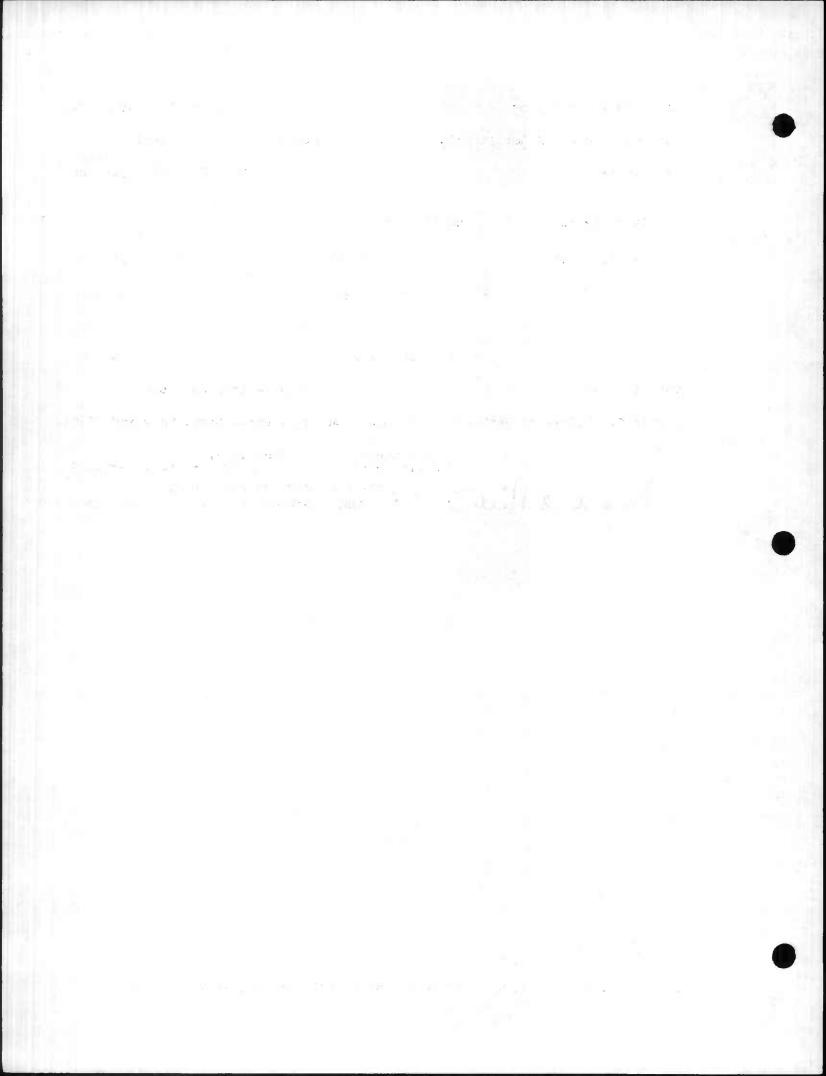
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	edica ımine		4e. Facility Neme (If not institution	, give street and r	number)			- (	lb. City, To	own, or L			4c. County			
End			Sunrise Care an	nd Rehab:	ilitatio	on			Elkto	on			Ceci	1		
Fune	ral		5. Sociel Security Number	6. Sex	7. Age (In yrs	s. last birthdey)	If Under				8. Dete	of Birth		9. Birthpl	aca (Stete	or Foreig
Direct			214-26-5488	1□M 2√2F	6	59 Yrs.	Months	Deys	Hours	Min.	May	18,	1929	Mary.	(ry)	
D			Usual Residence of Decedent									70.				
how	9 .		10a. Stete 10b. County		10c. C	City, Town or Loc	cation							10	Od. inside (	City Limite
Me H		000	Maryland Ceci	1	Nor	rth East	=								1 🗆 Yes	8 2 ₩ No
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2 should be filed within and Mental Hygiene. Is marked other than sumatic event.	1	0	Thomas Widdoes										Olsen			
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of H			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	20b.	Plece of Dispos cemetery, crem	sition (Nemoter)	e of ther plea	(e)	-	Dete		Oc. Location	- City or To	wn, State	
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permit. Peges 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra	DUC.		21. Signature of Funerel Service	Licensee		22.	. Neme end			ity						
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32. Registrer's Signeture

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Dey, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month Physician Elsie Veronica Craig December 27, 1998 0230 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 25 F Yrs 215-18-0691 87 **Director** June 23, 1911 Maryland **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits -how ral", or items 23s or 28s-f shore 1X Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 428 Market Street 21078 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 72 hours effec 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 natural, or 1 Yes 2 No Specify: Specify: P 3 KINVidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72. Department of Heelth and Mental Hygiene. Important! if frem 27 is marked other than "natuary findury or other treumatic event." Amtrak Railroad Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Ticket Agent Chester, Pennsylvania altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Winfield Scott Julia Veronica McLhinney 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7004 Emerson Street, Hyattsville, Maryland Stanley N. Craig (nephew) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State WBurial 2 ☐ Cremetion 3 ☐ Removel from State 12/30/98 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188 23a. Part. Enter the disease, or complications that caused the object. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onsel and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical MYOCARDIAL 3 DAYS Examiner Examiner Herry MGESTIVE YEATES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown S Q 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 20 No Hospital: 1 □ Logatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Division 1 Watural death. 1 □ Yes 2 □ No 2 Accident ofter death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(s) and manner es ststed. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nama and eddress of person who completed cause of de m 23a) (Type, Print) Newark, DelAWARE 19711 SUBURBAN S. LEY 412 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State DEC 3 0 1998 Registrar

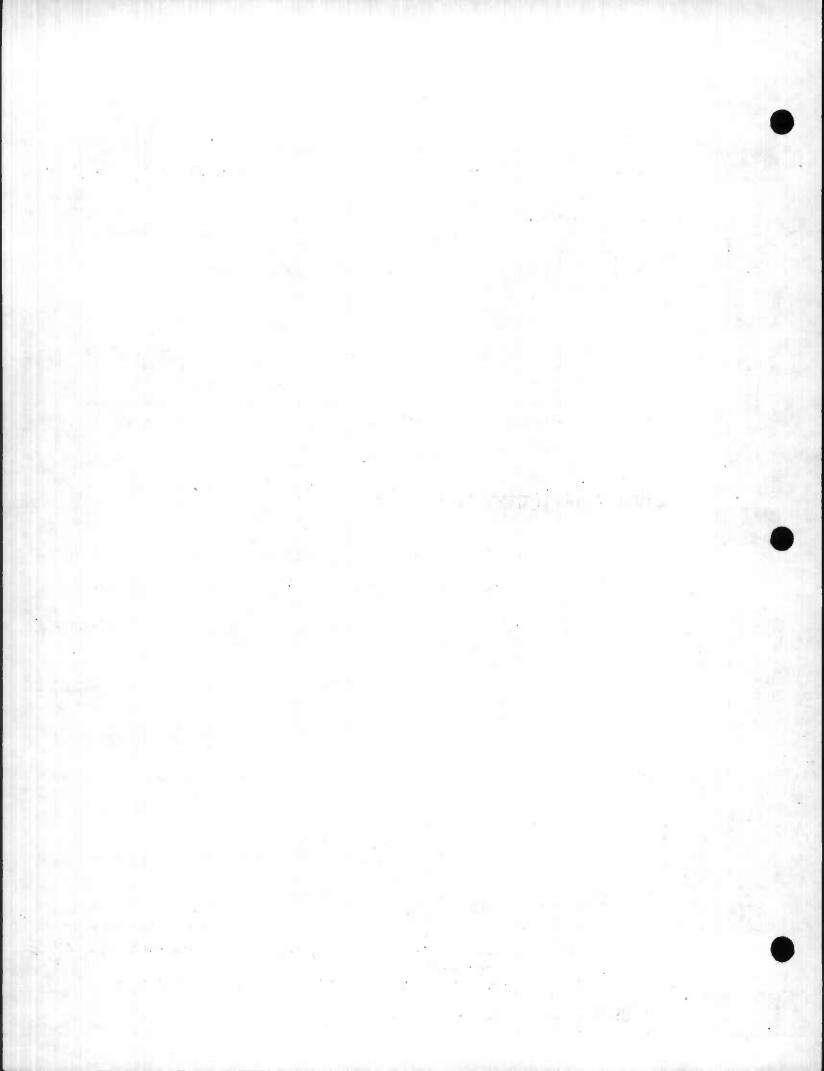
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 4 4 5 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey **Physician** December 26,1998 807 MARY MASGIB

4a Fecility Neme [If not institution, give street and number] /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8, Date of Birth Amonth, Dey, Year) If Under 1 Year 9. Birthpiece (State or Foreign Country) 5. Sociei Security Number 7. Age (in yrs. last birthdey) **Funeral** Deys 216-14-9539 1 M 2 Yrs. Director Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Wicomico 1 1485 2 No SALISBURG Director mde 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 741 5. DIVISION 21801 454 Funeral Peges 1 and 2 should be filed within 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forces? Wea Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Biack, White, etc. 11. Maritei Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Yes 2₽ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced 16b. Kind of Buainess/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) pernit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementery/Secondary (0-12) College (1-4or 5+) Emp. 1) omost 12 18. Mother's Neme (First, Middle, Melden Surne 17. Fether's Neme (First, Middle, Last) Cuxtis NOAL NOL Word 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) EVELETT resund DAuther 24 Salisburg MARY JRAN Mon 2/80/ 20b. Place of Disposition (Name of cametery, cremetery or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 1349 ACRE 4 ☐ Donetion 5 ☐ Other (Specify) MEM 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility any in 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dring, such as cardled or respiretory arrest, shock, or heart failure. List only one cause on each line. SALIBAR Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner by Physician/Medical Examiner ettending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of): 98 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the ceuse of death? the signed by the Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Waa an eutopay Completed hes 1 Tyes 2 No certificate 1 Yes 2 DAG or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA erel Director: After this filled in by the funeral di 28d. Describe how injury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28h. Time of 28c. Injury et Work? Naturel 2 Accident 5 Pending Investigation 1 Yes 2 No death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Direct 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(a) end manner as stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifie 29c. License number 248 December 26,1998 30 Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 540 KIULRSIDE

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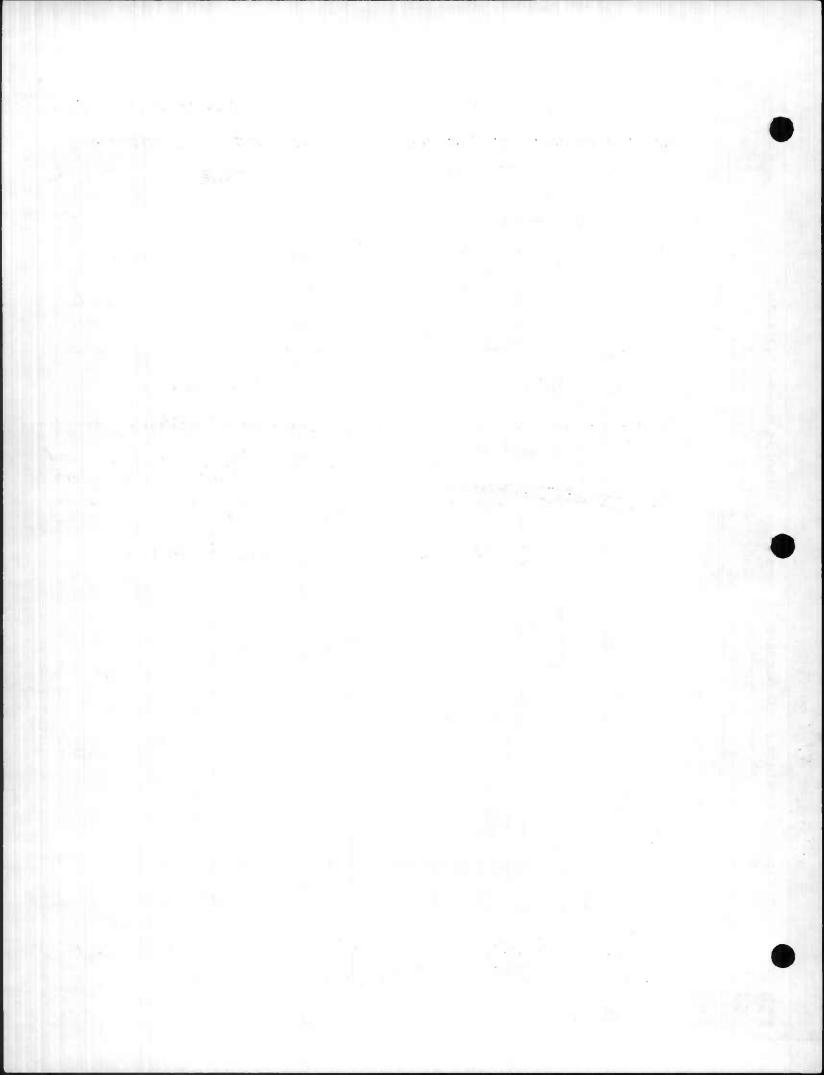
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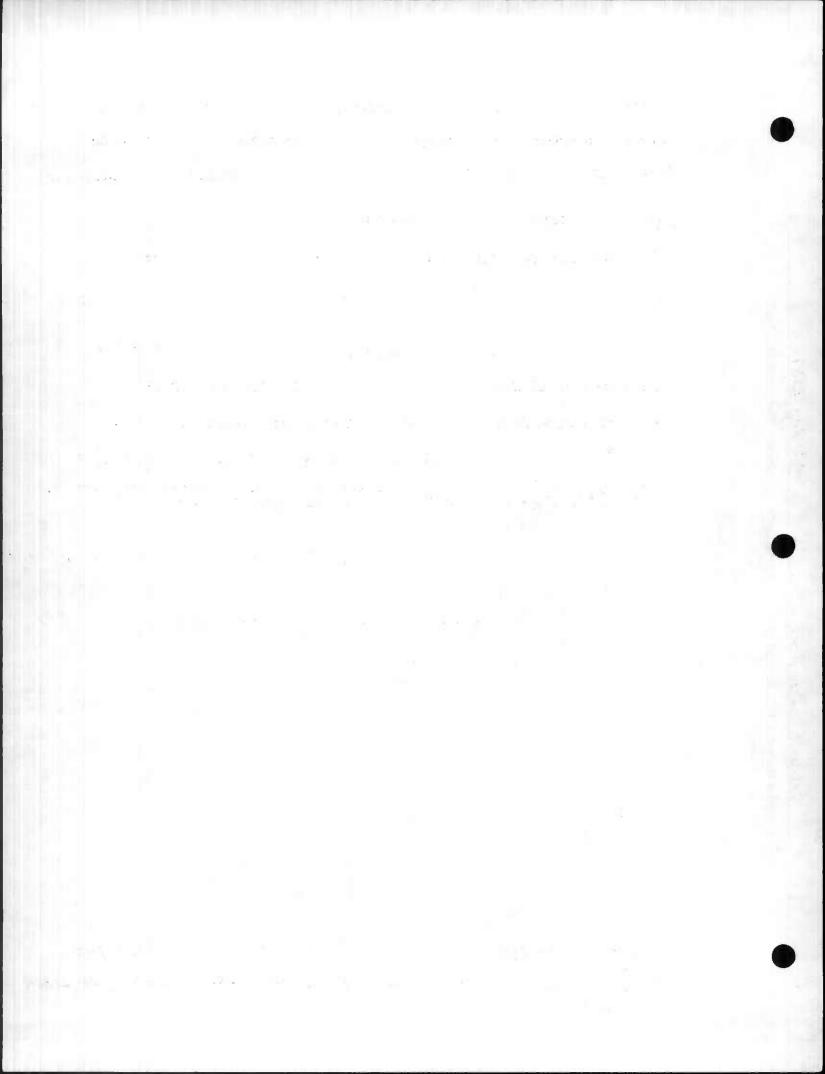


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State Registrar 31. Date filed (Month, Day, Year)
DEC 3 1 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** December 28, 1998 Ethel M. Ferguson 8:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Nursing Home Elkton Cecil W Under 1 Year | M Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 KF 1924 Pennsylvania 197-12-1284 74 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Pennsylvania Chester Landenburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 Strickersville Rd. 19350 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Merried 1 Yes 2 X No If Yes, Give Year or Dates: 1□ Yes 2Ū No Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family Farm 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Enos B. Ferguson Jeanette Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 Strickersville Rd. Landenburg, PA 19350 James Ferguson/Brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method ol Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal Irom State New London Pres. Cemetery 1-2-99 4 ☐ Donation 5 ☐ Other (Specify) New London. PA 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 21. Signature of Faneral Service Licenses scharo 111 S. Queen St. Rising Sun, MD 21911 e e death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death Imm ciate Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part t. drocepha 3 Probably 4 Unknown Yes 2 No Completed by 24b. Wara autopsy lindings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 10 Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 Natural
2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

The lew requires that the death certificate be executed Box 68760. P.0. Records, Division of Vital or Attending Physician: Hospital

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After

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Funeral Director: A

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**Funeral** 

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**Physician** /Medical

Examiner

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21215-0020

Baltlmore, Maryland

State Registrar 29b. Signature and title of certific

**DHMH 16 Rev 6/95** 

32. Registrar's Signature

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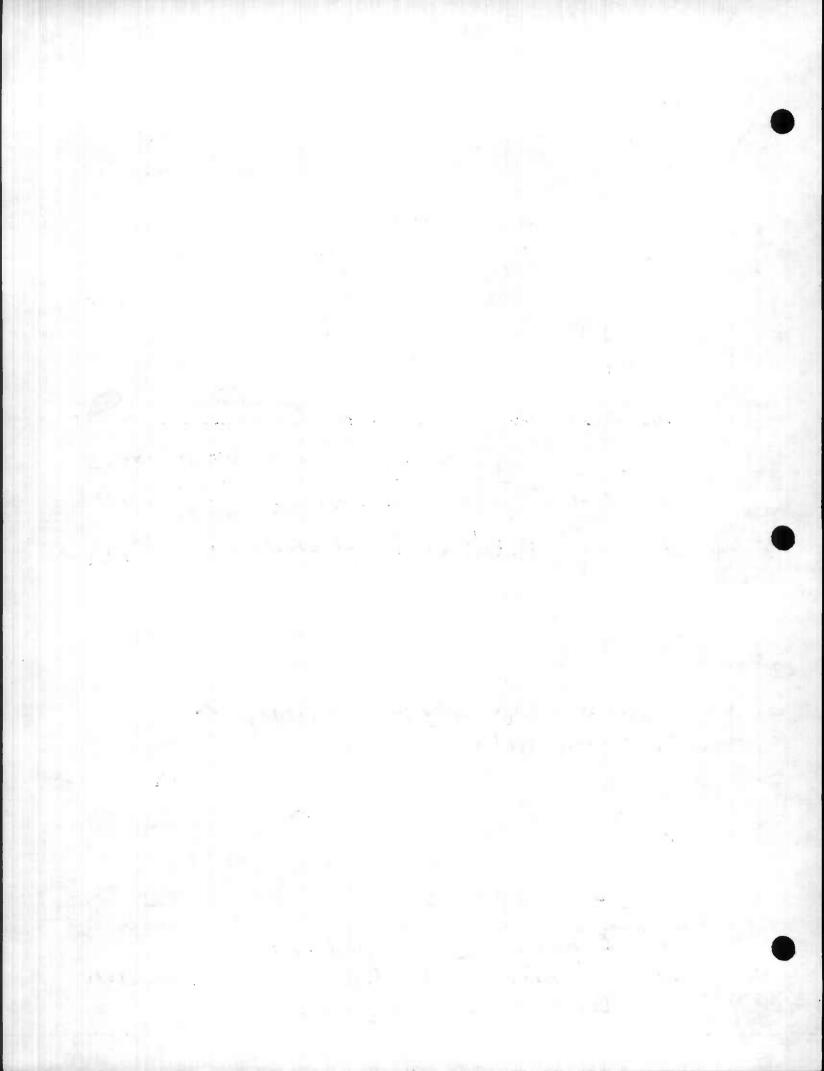
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29c. License number

29d. Date signed (Month, Dev. Year)

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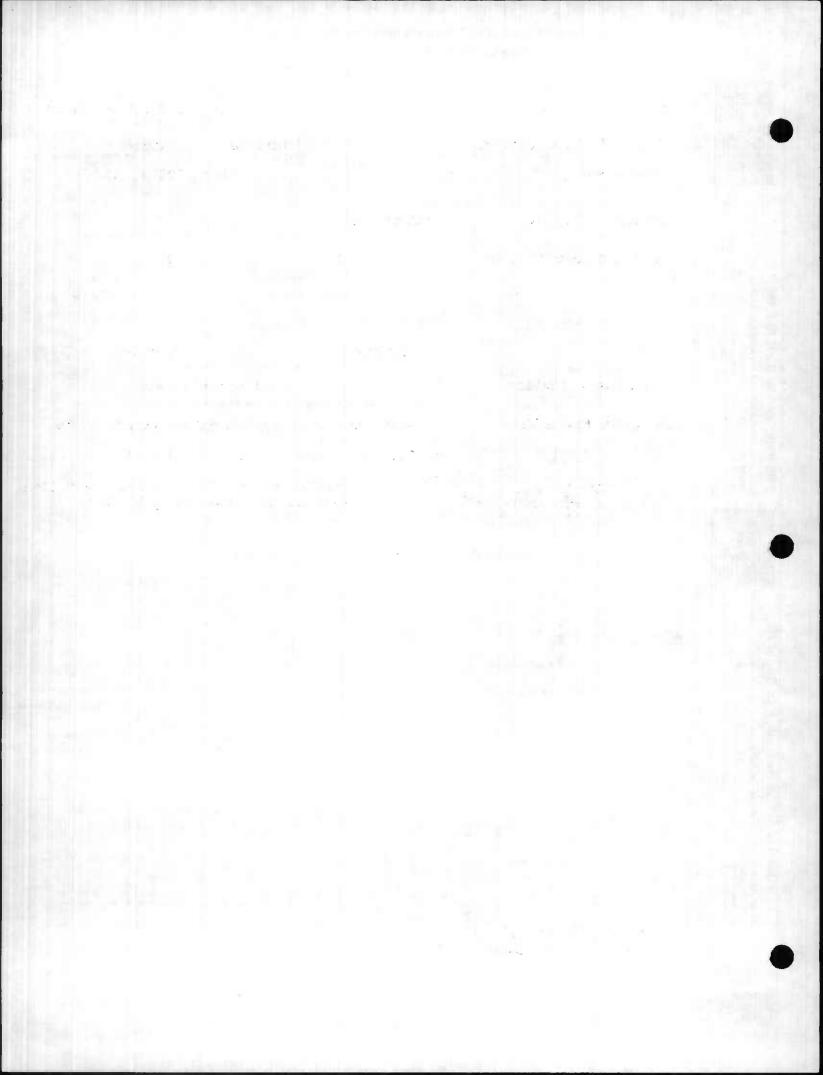
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Physician /Medical	Decedent's Name (First, Middle, Last)     Mildred M. Feliciani	2. Dete of Death Month Decembe:	r 30, 1	
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Ferronal	123 Whitehall Road Elkto  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Cecil	
Funeral Director	Months Days Hours Min.	(Month, Day, Y		9. Birthplace (State or Foreign Country) ennsylvania
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Sa-f s	Maryland Cecil Elkton			1⊠Yes 2 No
ufer deeth with the Me ifer man 23a or 23a-7s from 13b prouter Funeral Director	10e. Street and Number 123 Whitehall Road 2192		Citizen of Wh	States
me 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.		14. Race	- American Indian,
5-UUZU 72 hours after deeth with the Meryland natural; or items 23s or 28s-f show dital Examiner must be notified at	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☒ No  If Yes, Sho to the Yes, Sho to the Yes, Sho to Year or Dates:  Armed Forces?  If Yes, specify Cuben, Mexican, Puerto the Yes, Sho to Year or Dates:	o Ricen, etc.)		White, etc. White
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2 should be and Mentel Is marked of surmatic every	19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Run			tate, Zip Code)
	Marsha Feliciani/ Daughter 1065 Kawaiahao Street,	, Honolul	u, Hawa	ii 96814
	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other piece)  20c. Method of Disposition (Name of cemetery, crematory or other piece)	Dete 20 Der 30, We		ity or Town, State
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Dealth Pag Department Important: I eny injury o	21. Signature of Fune of Service Licensee 22. Name end Address of Facility Hicks Home for Fune	erals. P.	A.	
	and enter the disease, of implication, the disease of the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cruse of each line.	Street, Ell	kton, Ma	ryland 21921 Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  A cute Myelo cy  Due to (or as a consequence of):  Castrus, Can cer	he le	enker	ma
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been should		24a. Was an performe	autopsy ed?	24b. Were autopsy findings available prior to completion of cause of death?
The ate h		1 🗆 Y66	27Mio	1 ☐ Yes 2 ☐ No
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tal or Attending P is after deeth.  In Director: After ted in by the funers Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,		r or Rural Route Number,
Hospi 4 hou Funer taly fill	29a. Certifier (Check only one)  Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and manner stated.	, and due to the cau rred at the time, date	se(s) and man e and place, ar	ner as stated. nd due to the cause(s)
To the within To the comple	29b. Signature and title of certifier  29c. License number  D18940	290	d. Date signed $2-3$	(Month, Day, Year) 0 — P
10	30. Name and eddress of con who completed cause of death (Item 23a) (Type, Print) / 4/9h 5/4/10 31 (Month, Day, Year) 32. Registrer's Signature	04, E1	Kton	m021904
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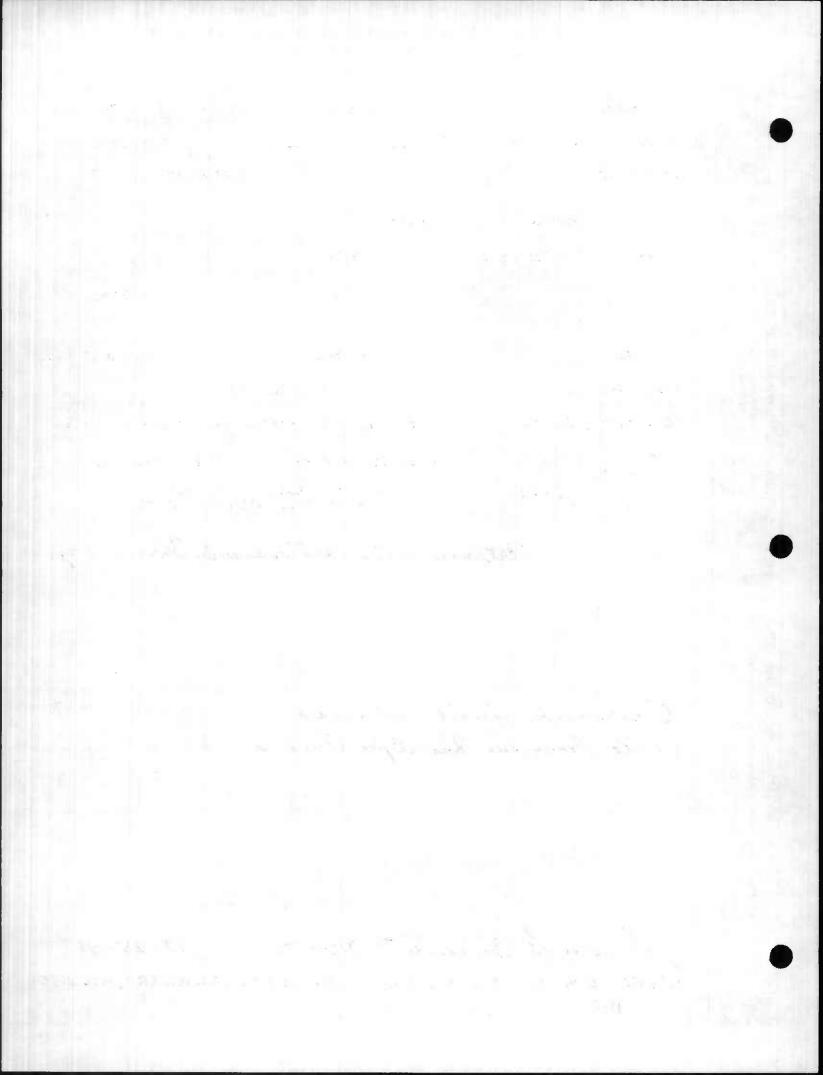
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State Registrar

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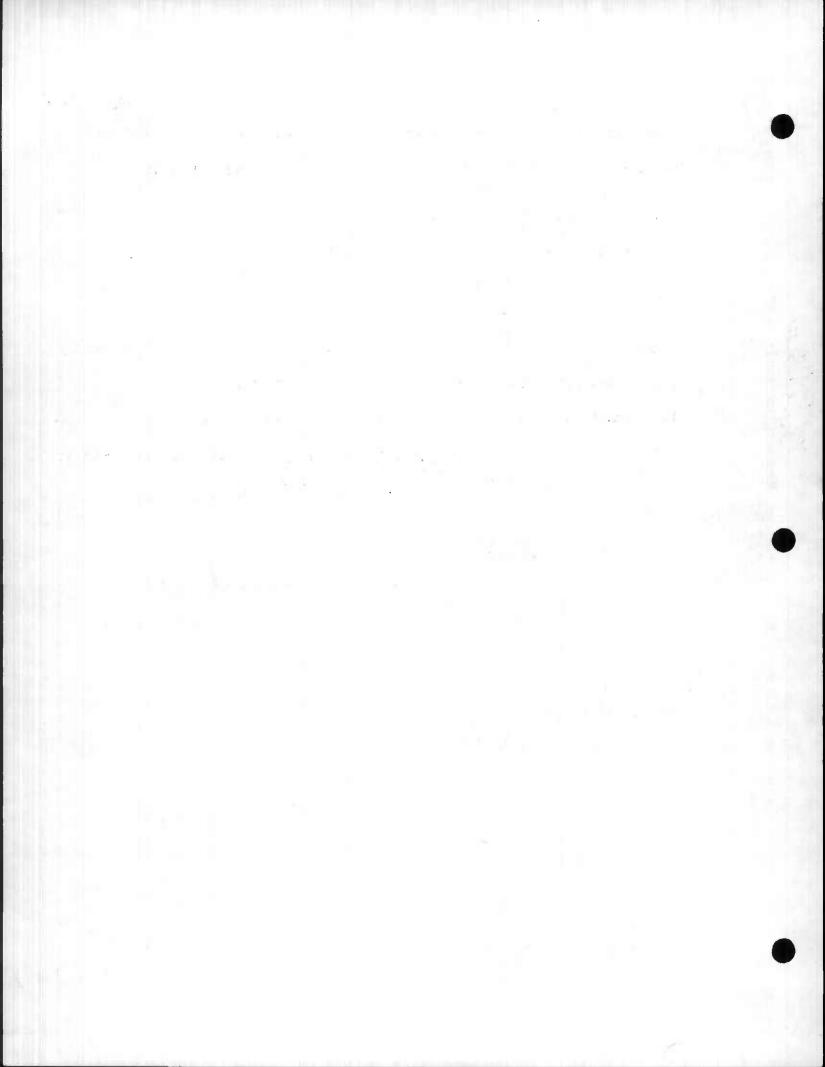
32. Registrar's Signatura



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	H. W.				Cert	ificate of	Death		Reg. No.			
Physician	1. Decedent's Name							2. Data of De Month	Day	Year,	3. Tima of Death	
/Medica	Georgia						4b. City, Town, or L	NUC		1998	1506	
Examine		4a Facility Nama (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER								4c. County of Death WICOMICO		
Funeral Director	251-54-761	5. Social Security Number 6. Sex 7. Aga (In yrs. 251–54–7614 1 M 2C F 84					aar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yaar) April 17,1914			9. Birthp Coun	iaca (Stata or Foreign try)	
and **	Usual Residence of I	10b. County		10c. City	, Town or Loc	ation				1	0d. Inside City Limits	
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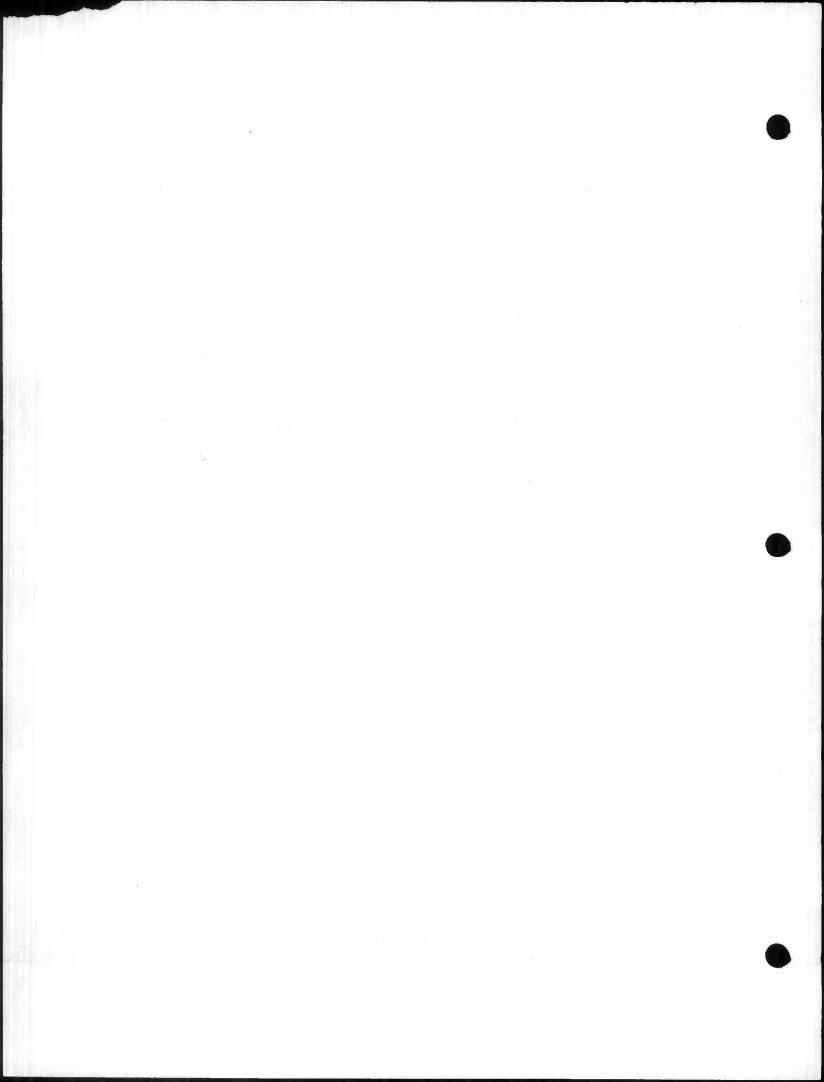


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending ph	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu	DOURS	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN		
	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Linda Ellen	Higgins				Decemb	er 30	1498 00;30 M
	Charles and Control of the Control		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1	. BIRTHPLACE (State or Foreign Country)
1 1	137-42-4073	□ M 2 🙀 F	50 YRS.	MONTHS DAYS	HOURS MIN.	July 19,	1948	New Jersey
	9e. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN	OR LOCATION OF DE	EATH	9c. COUNT	Y OF DEATH
DIRECTOR	559 Marley Road			Elkton	1		Cec	il
띭	toa. STATE tob. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d, INSIDE CITY LIMITS?
	Maryland Cec	il		Elkto	1			1 ☐ YES 2 🔯 NO
\¥	10e. STREET AND NUMBER			to	. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL	559 Marley Road	****			21921			ed States
	1 Never Merried 2 Merried	FORCES? 1 YES	2 XNO	If yes, s	ecify Cuben, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	s or No 14	t. RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR O	AIES	1   YES	2 NO Specif	у:		Specify: White
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ON opieted)	18e. DECEDENT'S	USUAL OCCUPATI	ON ast of warking	teb. KIND OF BU	SINESS/INDUS	STRY
Ē	Elementary/Secondary (0-t2) C	ollege (1-4 or 5+)	Account Vice Pr	e retired.)				
MP.	t7. FATHER'S NAME (First, Middle, Lest)	4	Vice Pr	esident		Bankii		
	Theodore John Higgi	7.0					Sumame)	
BE	190. INFORMANT'S NAME (Type/Print)	.115	19b. MAILING	ADDRESS (Street		Meaney Route Number, City or Tow	m. Stete. Zip C	ode)
5	Joy Kalmbach / Comp	anion			ad, Elkt		1921	
	20a. METHOD OF DISPOSITION 1 Burlel 2 X Cremation 3 Removal		. PLACE AND DATE of		ame of			y or Town, State
	4 Donation 5 Other (Specify)	R.	A. Ferri	s Crema			t Ches	ster ania
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			nd address of fa			
	Wolf The					Street, 1	North	East MD 21901
	23. PART I. Enter the diseases, or com ahock, or heart failure. List	plicetione that cause only one cause on e	d the death. Do reach line.	ot enter the me	de of dying, suc	ch ee cardlec or reep	iratory erree	Approximeta
	IMMEDIATE CAUSE (Fine)	0 +						Oneat and Death
	resulting in death) a	Breast DUE TO (OR AS	Concey	P				6 years
-		bue to lon as a	CONSEQUENCE O	·).				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	F):				
S	cause. Enter UNDERLYING CAUSE (Disease or injury							
E	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):				
띯	d							
AL	PART II. Other aignificant conditions c	ontributing to death b	out not resulting	in the underlyin	g cause given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						1 _ YES :		COMPLETION OF CAUSE OF DEATH?
								1 TES 2 NO
N.	DID TOBACCO USE CONTRIB	UTE TO CAUSE C	26. PLACE OF OEA			NE		
HYSICIAN:		OSPITAL:		OTHER:	./			
HXS	27. MANNER OF DEATH	Inpatient 2 ER/Outs	28b. TIM		JURY AT	8 Other (Specify)  28d. DESCRIBE HOW	INJURY OCCU	RED
0	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJ		YES 2 NO			
р ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	/ — At home, ferm,	street, fectory, offi	ie .	28f. LOCATION (Street City or Town, State	end Number or	Rural Route Number,
ETED	4 Homicide determined	Suitarry, etc. (Spor				City or lown, State	,	
7.		N: To the best of my know	rledgs, death occurr	ed at the time, dat	end place, end due	to the cause(e) end ma	nner as stated	
COMPL	one) 2 MEDICAL EXAMINER: C	In the basis of examination	n end/or investigation	n, In my opinion,	Seath occured at the	time, dete end place, er	nd due to the	cause(s) and manner es stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DATE 5	SIGNED (Month, Day, Year)
0	of to mus,	~ 1)			715	714	1 The	c. 30, 1998
	30. NAME AND ADDRESS OF PERSON WHO CO		ATH (ITEM 27) (Type	Print)	h. 14.	1/10 E 1/17	~ M	D
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		in per	in prosp	ICE EIKI	Uh, /	7
	DEC 3 1 1998	Beneva	B	lower	,			
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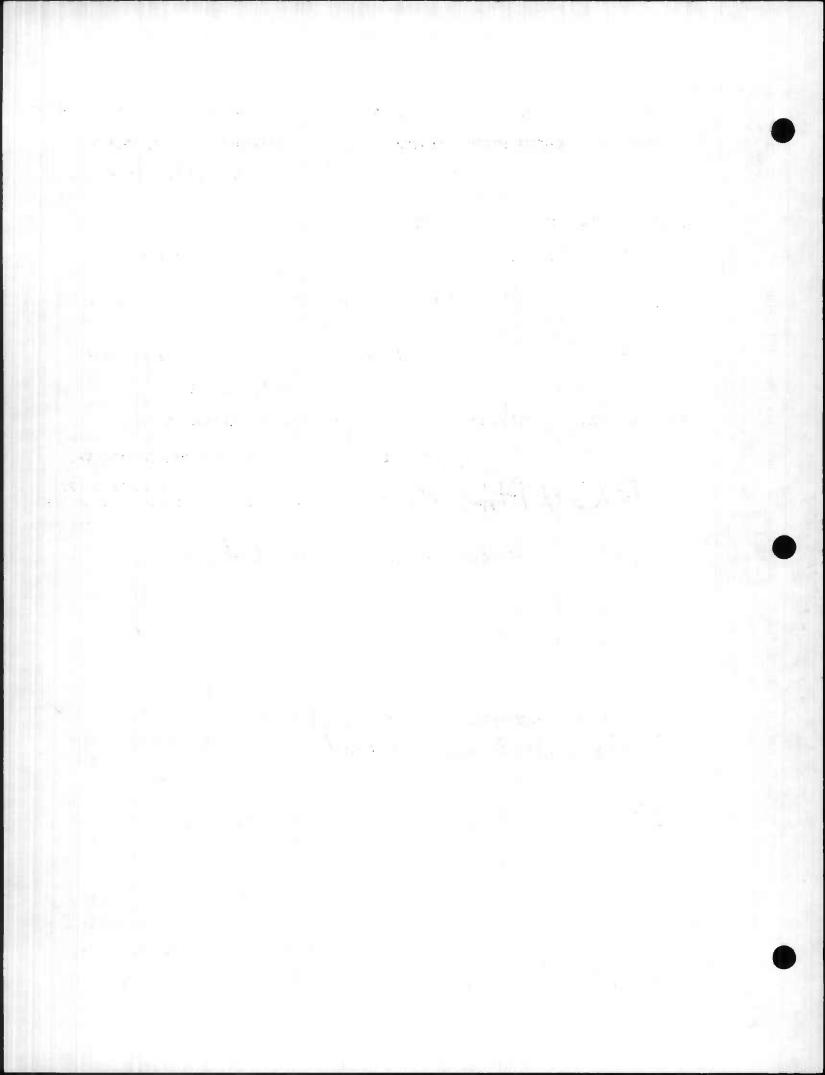
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aryland / Department of Health and Mental Hygiene		13	J	J
Cartificate of Dooth				

				Certificate	of Deat	h		Reg. No.		
	1. Decedent's Neme (First, Mid	die, Last)	100				2. Dete of De Month	eth Dey	Year	3. Time of Death
Physician /Medical	EDWARD	THOMAS	1	HUGHES			Decembe		998	1206
Examiner	4e Facility Neme (If not instituti				4b. City,	Town, or L	ocation of Death	4c. County	of Deeth	
	PENINSULA R	EGIONAL MEDI	CAL CENTE	ER		SALIS	BURY	WI	COMIC	0
uneral	5. Social Security Number	6. Sex 7. /	Age (In yrs. last birt	Months	Year If Und	er 24 Hrs.	8. Date of Bird (Month, De	h		lace (Stete or Foreign
ector .	214 10 9437	IASM ZUF	81	rs.			JULY 18	3,1917	MARY	
ector	Usuel Residence of Decedent  10a. Stete 10b. Coun	tv	10c. City, Town	or Location					11	0d. inside City Limits
ai Director										1 ☐ Yes 2 ☒ No
Director	MARYLAND WORC	ESTER	POCC	MOKE 10f. Zip C	ode			10g. Citizen of	What Coun	itry?
ă	1829 BUCK HA	DRUD DU			1851			U.S.A		,
Funeral	11. Meritef Status	12. Wes Deceder	nt Ever in U.S.			Origin? (Sp	ecity Yes or No		e - Americ	an indian.
F	1 Never Merried 2 Me	Armed Forces	s? TNo	13. Wes Deceder if Yes, specify	Cuben, Mexic	can, Puerto	Rican, etc.)	Ble	ck, White,	etc.
by	3 X Widowed 4 ☐ Divorce	If Yes Give	ARMY	1 ☐ Yes 2💢	No Speci	ty:		Specif	WHIT	E
		ent's Education	16e.	Decedent's Usuel (	Occupation		. In a	16b. Kind of B		
Be Completed	(Specify only high Elementery/Secondary (0-12)	college (1-4o	r 5+)	(Give kind of work life. DO NOT use	retired)	ost of Work	ung			
COL	12			REPAIRMAN				SELF-E	MPLOY	ED
36 (	17. Father's Name (First, Middle				18. Mo	ther's Nam	e (First, Middle,	Maiden Sumar	ne)	
10	CHARLES V. HU	GHES			MAI	RY A.	FITCHE'	ГТ		
	19e. informent's Name/Reletion			Mailing Address (						Code)
	LORIE A. DEAN -	- GKANDDAUGH		2 WILLIA		FR	UITLAND			
	20e. Method of Disposition 1 → Buriel 2 □ Cremetion	3 Removel from Stel	cemeter	Disposition (Neme , crematory or oth	er plece)	1	Dete	20c. Location		
	4 □ Donetion 5 □ Other		NELSON	CEMETER	Υ	1.	2-30-98	NEW CHI	JRCH,	VA.
nose.  To Be Comp	21. Signature of Funescal Service	Licen e		22. Neme end	Address of Fed	cility		705 E	MATI	N ST
	15. Kee	the Phym	W CFSI	BOUNDS	FUNERAI	HOM	E.INC.			MD 21804
	23a. Part1. Enter the disease, shock, or heart feilure. Li	or complications that caus st only one cause on each	ed the deeth. Do n	ot enter the mode	of dying, such	es cerdiac	or respiretory a			Approximete Intervei Between
cian				1		)	1			Onset end Death
lical iner	Immediate Cause (Final disease or condition	Ceve	busic.	wan	0.00	. 6	ut			
	resulting in deeth)		Due to (or es a c						1	
edical Examiner		b								
хап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2500.00	Due to (or es e c	onsequence of):					-	
a E	cause. Enter Underlying Ceuse (Disease or Injury that Initiated events	C								
op	thet initieted events resulting in deeth) Lest		Due to (or es e co	onsequenca of):					i	
3		d								
clar	Deat # Other class	Mana anat-ferrito de de 11	hut not and the	the condition		4.1	not Did	tohoono	menth of a	the ourse of death
ysl	Pert ff. Other significant condf	tions contributing to death	Dut not resulting in	me underlying cau	se givenin Pe	rt 1.		Yee 2 No	3 Prof	the cause of death?
y Physic	Churc	atria	X	-6-,6	atr		10	144 YUN0	O Pro	July 4 Olikilowi
sctor, page 2 should be detached for us Be Completed by Physician	()		$\cap$	/ )	1		24a. Was	en autopsy	24b. W	ere autopsy findings
pe 2 should I	20000	nterti	ren	lober	7		perfo	ormed?	CO	ailable prior to mpletion of cause death?
d E							10	Yes 2010		Yes 2 No
S	25 Was open referred to media	eal .			00.01	200 of D-			1	7 192 S□ MO
8	25. Was case referred to medic examiner	Hospital:	tiont of the	nations of DC:	Other:		th (Check only o	The second	has /0*	M
oral director, page 1: To Be Com	27. Marrier of Death	142 Inpa	the second second second		. Injury at Work?	Nursing H	ome 5 Resi 28d. Describe	dence 8 LIOti how injury occu		y/
tlon	1 □Natural 5 □ Pend	28e. Dete of Ir (Month, L stigetion	Dey Year) In	jury M	Work? 1 ☐ Yes 2	□No				
fica	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Piece of i	njury - At home, fer				28f. Location (	Street and Num	ber or Rura	al Route Number,
erti	4 Homicide	building,	etc. (Specify)				City or To	wn, State)		
Medical Certification: To	29a. Certifier Certify	ing Physician: To the bes	st of my knowledge.	deeth occurred et	the time, dete	end pleca.	end due to the	cause(s) and m	anner as s	tated.
D		I Examiner: On the basis end menner	of examinetion end							
Me	29b. Signature and title of certif	jer		29c. l	icense numbe	er		29d. Dete sign	ed (Month,	Dey, Year)
A	1 ()	_		0	1-1 -	7 (/	-	4226	1	
10.	30. Name and eddress of perso	n who domnieted cause of	death (item 23a) (	Type Print)	/	7	1	(30	*	
1	TA Cache	The state of the s	00 0		J. So	Lak	2. M	dere	14	
State	31. Dete tiled (Month, Day, Yes	32. Regis	strar's Signeture	· ·		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0-1			
Jiale	DEC 3		Geneva	4	1					
Registrar			1	61 11	1300 11					

DHMH 16 Rev 6/95

Edward Hughes 214-10-9437



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Hawks 9.25 PM 25 1998 Dec 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Head Conter Salisbury WICOMICO per's If Under 1 Year Montha Deva 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth
Month, Pay, Year)
JAN • 23, 1927
MARYLAND 7. Age (In yrs. last birthday) Deya Hours Min 257-38-7976 Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits SALISBURY WICOMICO MD. 1 ☐ Yea 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 351 DEER HEAD ROAD USA 21801 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: Specific FRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) TEXTILE WORKER 12th LABORER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) BULAH LITTLE HAWKS WILLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 771 NORWOOD STREET, GAINESVILLE, GA. REV. ADELL HAWKS 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) COMMERCE GA. 30529 BLACK SPRING CHURCH 12 - 3021. Sign ture of Funerel Servica Licangee 22. Neme end Address of Facility JOLLEY MEMORIAL CHAPEL 1213 jerseyROAD , SALISBURY, MARYLAND 21801 Enter the disease, or complication thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart fellure. List only one call a on each line. Immediate Cause (Final disease or condition resulting in death) Le repro Vascular accident - recurrent Due to (or es e consequence of) Sequentielly list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? injury with seizure disorder 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24e. Was an eutopsy performed? 24b. Were autopsy findinga evalleble prior to completion of cause of deeth? 45100 COPI 1 Yea 2 No 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d, Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

b

Completed

Be

P

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at

the USB cata has been signed by page 2 should be detact certificata this funaral After

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

The law requires that the death cartificate be

Medical Certification: To ours after death. eral Director: Af filled in by tha fu

Physician/Medical Examiner by Be Completed

1 Neturel
2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

5 Pending investigation 6 Could not be

28e. Dete of Injury (Month, Dey Year)

P.O.

1 Yes 2 No 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(a) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(a) end menner stated. 29b. Signature end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Salis bury Md 2018

State Registrar

31. Dete filed (Month, Dey, Year) DEC 3 1 1998

32. Registrer's Signeture

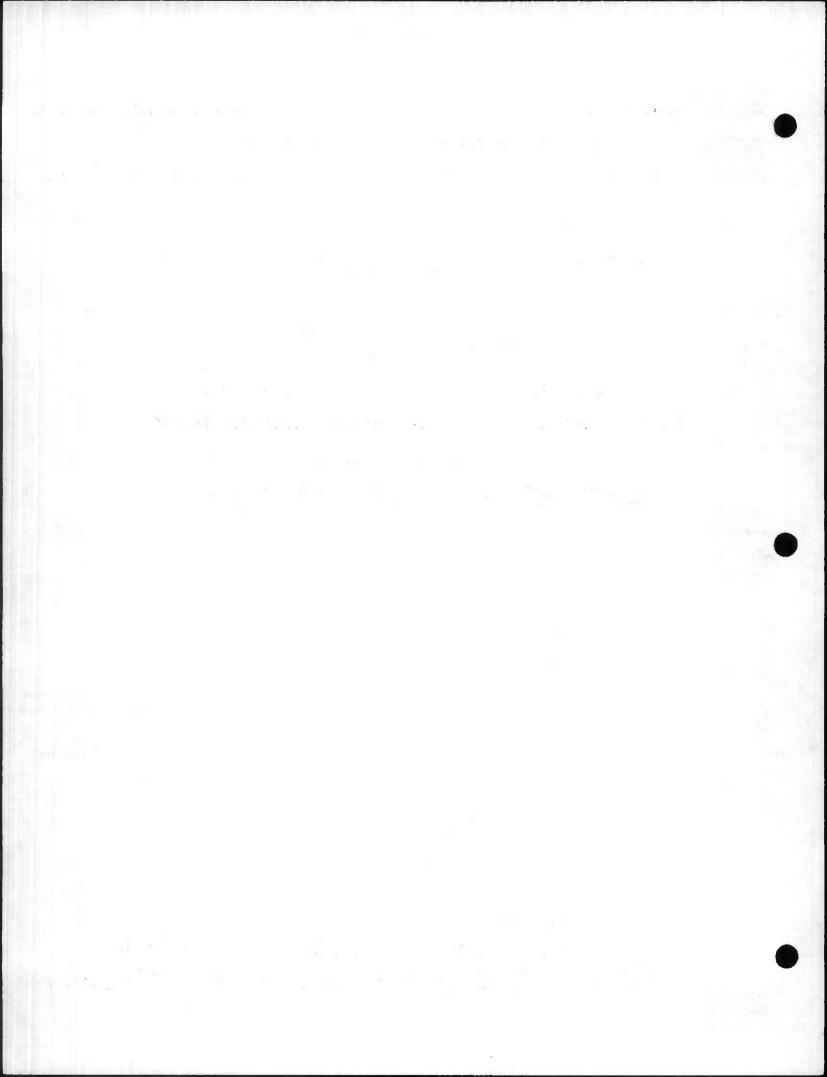
Box

To the Hospital o within 24 hours af To the Funeral D completely filled i

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	_				Certifica	ite or	Death				. No.		1	
Physic	ian	Decedent's Neme (First, Midd							2. Dete d Month	1	Dey	Yaar	3. Tima	of Deeth
/Medi		Wanda R. Irack							Decer			98	10:40	PM
Exami	ner	4e. Facility Neme (If not instituted Calvert Manor	a transfer and the second				4b. City, To Risin			Deeth	4c. County Cecil			
Funeral		5. Sociel Security Number	T - T	7. Age (In yrs. las		er 1 Yeer	If Under	24 Hra.		of Birth			iace (Stete	or Foreic
Director	L	075-12-2971	1□M 2X)F	77	Yrs. Month	s Deya	Hours	Min.	8. Dete d (Monti AUG •	1, Dey, Y	1921	Penn	piace (Stete ptry) SYLVAI	ria
2		Usuei Residence of Decedent  10a. State 10b. County		10a City	Town or Location								Ad 1 - 14 -	min . A f to
death with the Maryland ms 23a or 28a-f show constitute notified at	o.		,		ticoke								Od. Inside	s 2 N
28a-f	Funeral Director	PA Luze	rne	Nara		Zip Code				100	. Citizen of	What Cour		
23a or	D	248 W. Main St				1863	4				JSA	VIII. 000	,	
Home 2	ner	11. Meritel Stetus	12. Was Dece	dent Ever in U,S.	13. Wea Dec			igln? (Sp	ecify Yes		14. Rad	e - Americ		
or He	by	1 Never Married 2 Mar 3 Widowed 4 Divorced		2 Ø No e		2 No	en, Mexicar Specify:		Rican, etc	).)	Specif.	ck, White, y: Wh	elc. ite	
natural',	Completed	15. Deceder	nt's Education est grade completed)		16a. Decedent's Us	suel Occup	oatlon	et of work	ina	16	b. Kind of B			
trail Hygiene. d other than "natu	nple	Elementery/Secondery (0-12)	College (1	-4or 5+)	(Give kind of a life. DO NOT		d)	si or work	ary.					
her ti	ပိ	17. Fether's Neme (First, Middle,	/ cot)		Housewi	6e	40 Math	aria Marri	o /Final 14	Intella Ada	Home			
should be med withing the Mental Hygiene.  marked other than ametic event, the Mental Men	Be	Stanley Grynie						-	Bauri		iden Suman	ne)		
ges I and 2 should t of Health and Mer If Nem 27 Is marks or other traumatic	7	19a. Informant's Name/Relations			19b. Mailing Addre	ss (Street					City or Town	State Zir	Code)	
4 2 2 2		Dr. Edwin Irac			11 Josh'.							, Olato, E.p.	0000,	
Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition		20b. Ple	ca of Disposition (A				Dete		c. Location	- City or To	wn, Stete	
nent of h		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State	Mary's C			i	1-4-9	9 W	ilkes	-Валл	e. PA	
Department of Important: If any injury or once.		21. Signeture of Funerei Service		1	22. Neme	end Addre	ss of Fecili	ity					-	
Depa impo		1614	-		R. T. 111 S.	Foar	d Fund	eral	Home	, P.	A.	01011		
hysician /Medical xaminer Examiner		resulting In deeth)	θ.	Aca	THE M	/								
	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	e	Due to (or e	es e consequence o	f):								
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cean centificate be associated e attending physician and of for use as the burial-transit	dicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b c d	Due to (or e	as e consequence o	f): i):	ven in Pert I	1.	23b.	Did toba	acco una co	ntribute to	o the cause	of death
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ate has been signed by the attending physician and page 2 ahould be detached for use as the burial-transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	THE MARKE	Due to (or a Due to (or a ath but not resulting ASC)	as a consequence of a consequence of the consequenc	f): j):	iska	Hal	24a.	1 Yae	2□ No autopsy	3 Pro	ere autopsy allah p mpletion of death?	Unkno
percent. The tark beginnes that the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions of the condition	Hospital: 1 - Ir	Due to (or a ath but not resulting the control of t	is a consequence of the conseque	g cause giv	28. Place	e of Death	24a.	Wes an approxime	2 No autopsy 2 No 2 No	3 Production Productio	ere autops) allah properties prop	Unkno
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tending reparement the same requires that the coath centificate by associated death.  tor: After this certificate has been signed by the attending physician and the funeral director, page 2 ahould be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions are sufficient to medical examiner?  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manper of Death 1 Matural   5 Pendia investi   2 Accident   3 Sulcide   6 Could determine   6 Could determine   1 Centry in the cause   1 Centry in	Hospital: 1 In Ing Ing Ingellon not be Inlined 28e. Place building Physician. To the ba	Due to (or a but t	as a consequence of a c	ocause gives of the first only, office	26. Place and year the? Yes 2   me, date an opinion, dea	e of Deathursing Ho	24a.  h (Check of the check of	Wes an approxime  1 □ Yes  only one)  Residence ribe how  lon (Street r Town, S	2 No autopsy  2 No	24b. W. av co of 1	ere autops allah a prompletion of death?  Yes 2,1  Your Route Number of the cause of the cause	Unkno findings cause No
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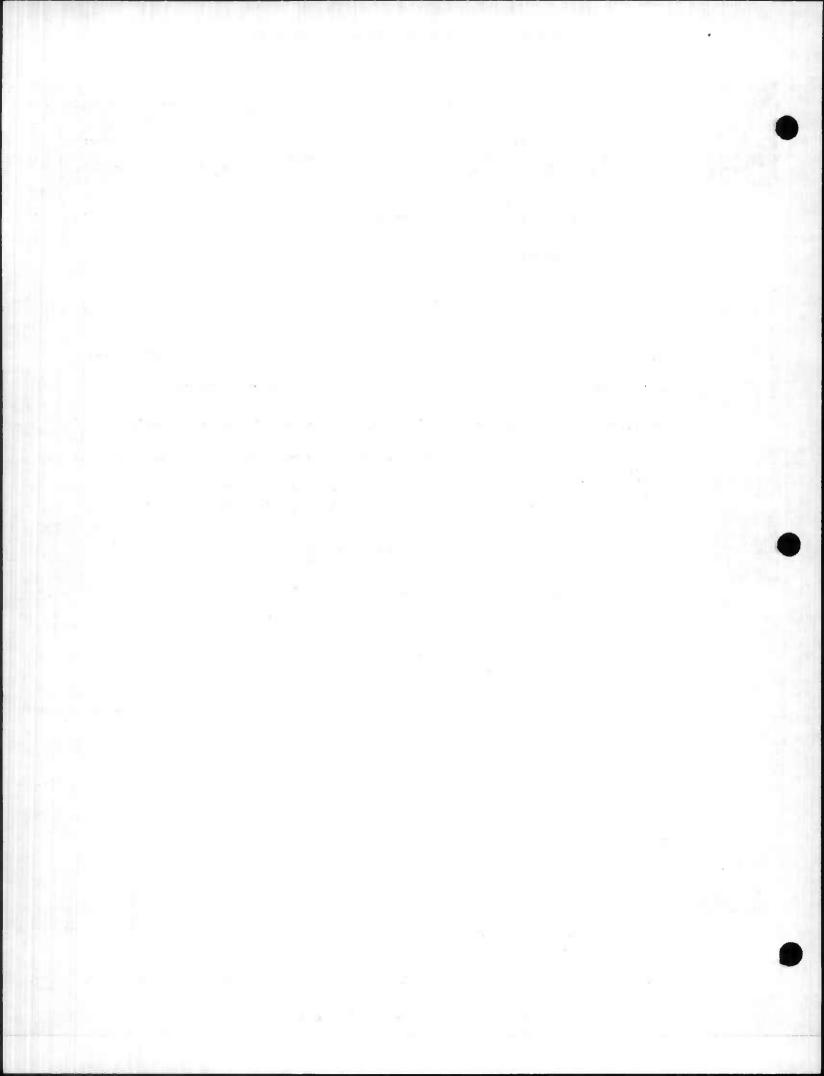
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## Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Dete of Death **Physician** Month Tawes McNamara Insley 27, 1998 1:45 PM December /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Dorchester Chesapeake Woods Center Cambridge | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | April 26, 1912 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** XX M 2□ F Maryland 86 220-03-6577 Yrs. **Director** Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Exercines result be notified at Dorchester 1XXYes 2 □ No Director Maryland Cambridge 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 525 Glenburn Avenue 21613 US Funeral 12. Was Decedant Ever in U,S. Armed Forces? NAYes 2 □ No If Yas, Giva Yeer or Datas: 42 45 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck. White, etc. 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2(No by Specify: 3XWidowed 4 □ Divorced White Completed 16a. Decedant's Usuai Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry oe filed within 7 tel Hygiene. Elamantary/Secondery (0-12) Coilega (1-4or 5+) 11 Farmer Agriculture permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any injury or other traumatic event DREB. 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Herman Insley Blanche McNamara John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 525 Glenburn Avenue Cambridge, Maryland 21613 Mary I. Montroy Sister 20b. Piaca of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donayon 5 ☐ Othar (Specify) Dorchester Memorial Park 1/3/99 Cambridge, Maryland 21. Signatur Funarai Sania Licansee 22. Name and Addrass of Facility
Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Park. Entar tha disaase, or complications that causad tha deeth. Do not anter tha mode of dying, such es cardiac or respiratory arrast, shick, or haart failura. List only ona causa on aach lina. Approximata Interval Between Onset and Deeth **Physician** /Medical immediata Causa (Final nun disaasa or condition rasulting in death) Examiner -transit be executed Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Causa (Disaasa or Injury that immated events resulting in death) Last and Box 68760 Physician/Medical the P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown signed b Records. by 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? Completed 1 Yes 2 No. certificate Division of Vital Hospital or Attanding Physician: 24 hours efter death. 25. Was casa raferred to medical Be 28. Placa of Death (Check only ona) Hospital: 1 | Inpatiant 2 | ER/Outpetient 3 | DOA Othar: 4 Aursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 10 1 Yas 2 No. this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: After 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant Director: / 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Spacify) 4 D Homleida To the Hospital o within 24 hours eff To the Funeral DI completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifiar (Check only one) 29b. Signetura and title of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 12/30/98 30. Name and addrass of person who complated causa of death (itam 23a) (Type, Print) Aurora suece Cambridge MO21613. Almed Nawaz 105 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State DEC 3 0 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Deeth

9. Birthpleca (State or Foraign Country)

White

10d. inside City Limits

Approximete Intervai Between Onset and Deeth

30 min.

8 hours

24b. Were autopsy findings available prior to completion of causa of death?

1 Yes 210 No

1 Yes 2 □ No

2. Dete of Death

December 29 1998 8:14pm **Physician** NANCY ROSCOE JONES /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot Memorial Hospital | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | 9. Birthpleca (State or Country) | Oct 28 1929 | Illinois 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1□ M 2 F Months 69 Director 215-28-1170 Usual Residence of Decedent the Marylend 10s State 10c City Town or Location 10h County r than "naturel", or items 23s or 28s-f show the Medical Exampler must be notified at MD Oueen Anne's Centreville Director 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? with 21617 106 Corsica St. U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forces?

1 Yes 2 No If Yas, Give Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Meritel Status Bleck, White, etc. 72 hours efter 1 Never Merried 200 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Aq 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Queen Anne's Co. Elementery/Secondary (0-12) Coilege (1-4or 5+) Secretary Assessment Office 12 Pages 1 and 2 should be filed valent of Health and Mentel Hygie mt: If item 27 Is marked other t treumstic event. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17 Father's Neme (First Middle Last) Be Mabel Domier Robert R. Roscoe 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Roger C. Jones (husband) 106 Corsica St. Centreville, MD. 21617 other 1 altimore. 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition Dete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete 8 12/31/98 Dover, DE. 4 ☐ Donetion 5 ☐ Other (Specify) Capitol Crematory 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility any le Galena Funeral Home of Stephen Schaech M00510 Galena, MD. 21635 Box 235 23a Part Enter le riseese, or complications that causad tha death. Do not enter tha mode of dying, such es cardiac or raspiretory errest, slock, or le an fillura. List only one causa on aech line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Acute Cardiorespiratory Arrest Examiner Due to (or as e consequence of): Examiner Acute Myocardial Infarction certificata be axecuted physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of) 98 for use es ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yas 2 X No 3 | Probably 4 | Unknown Asthma Records. þ 24a. Was an sutopsy Completed peen performed? page 2 1 Tyes 2 X No certificate of Vital Hospital or Attending Physicien:
24 hours after death.
 Funeral Director: After this certifica director, 25. Was case referred to medical Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: Division 5 Pending Injury 1 Naturel 1 ☐ Yes 2 ☐ No

1. Decedent's Nema (First, Middle, Last)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, end due to the cause(s) and manner as stated.

| Medical Examíner: On the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) end manner stated. 29d. Data signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Dec. 30, 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

2540 Centreville Rd. Centreville MD. 21617 Russell A. Schilling D.O.

29c. License number

H 42587

State Registrar

filled in by

To the Hosp within 24 hou To the Funer completely fil

edicai

31. Date filed (Month, Dey, Year)
DEC 3 1 1998

investigation

6 Could not be

2 Accident 3 Suicide

4 Homicide

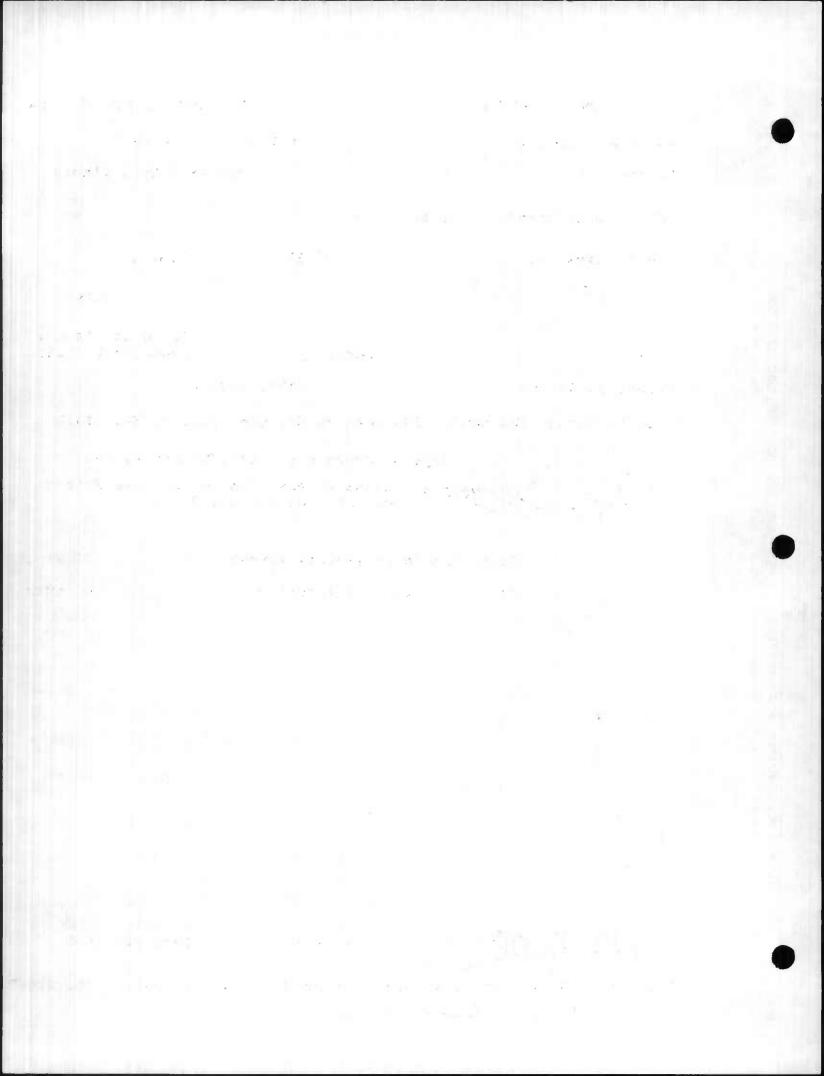
29b. Signeture and title of certifier

29a. Certifier



28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** FLVA LARMORE 27, 1998 4c. County of Deeth /Medical 4b. City, Town, or Location of Death 4:23 AM 4e Fecility Name (If not Institution, give street and number) **Examiner** Wicomico Wicomico Nursing Home Salisbury, MD If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Director 217-24-9645 92 May 13,1906 Minnesota Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d Inside City Limits items 23s or 28s-f show ner must be notified at Maryland Wicomico Salisbury 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 900 Booth St 21801 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus the Medical Examiner Black. White, etc. 1 ☐ Yes 2 XNo 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: λq White 3 XWidowed 4 □ Divorced Hygiene. other than "natural", Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Buyer Woodward & Lothrop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Peges 1 and 2 should be fit ment of Health and Mentel Hant: If Item 27 is marked oth Be Niles Frederick Larson Lottie Grace Watson 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Naomi L. Weitzel/Daughter 39 Chuckanutt Dr., Oakland, NJ 07436 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 12/30/98 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 21. Signa Service Licensee 22. Name and Address of Facility M01051 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Monuson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. **Physician** /Medical ardiovasculas Disease Immediate Cause (Finel disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the Bilateral Metastatie Lung Cancer 2 1 Yee 2月 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy Chemia 1 Yes 2 No TO Yes Zig No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this. 27. Manner ot Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

**600 60** P.O. Box 68760, Division of Vital il or Attending satter death. Hospital c 24 hours at Funerel D To the Hosp within 24 hor To the Fune completely fi

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State

Gregoria M. Belloso, MD - 5302 Chinaberry Dr., Salis., MD 21801

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0. Neme and woress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

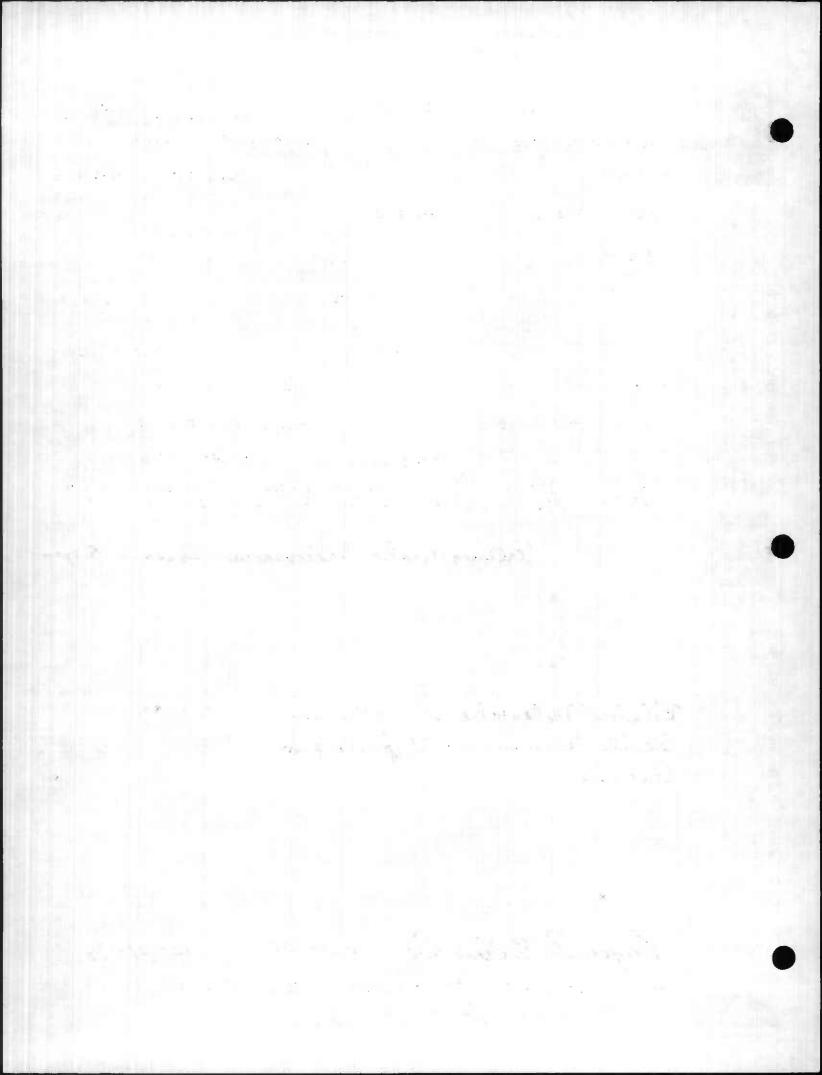
29c. License number

29d. Dete signed (Month, Day, Year)

12-27-90

31. Date filed (Month, Day, Year) DEC 3 0 1998 Registrar

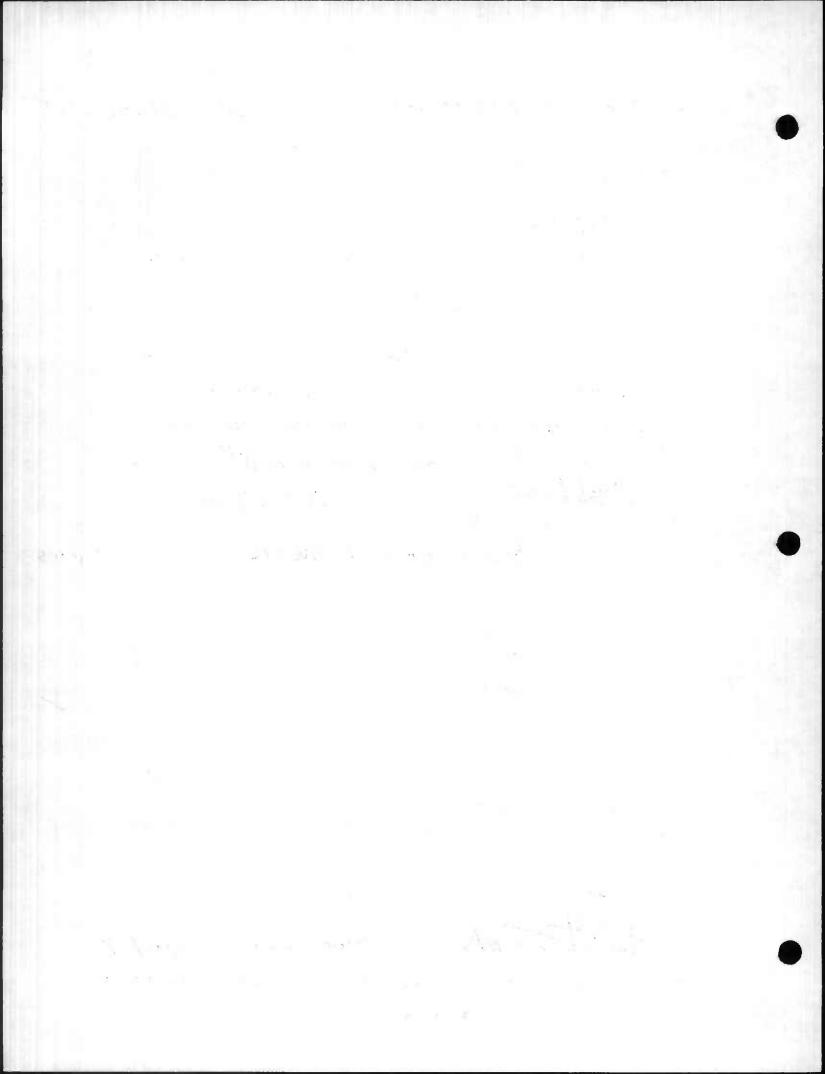
29b. Signeture end title of certifier



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die y	Dy L	1 ☐ Never Marrie 3 ☑ Widowed	ed 2 Married	1 ☑ Yes 2 ☐ If Yes, Give	No 8/17	7/42	1□ Yes 💥		Specify:		Speci	h:	
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metic	-	John M.	Moore me/Reletionship (T)	me Print)		19h Meili	nn Address (	Street	Ann M.  end Number or R		her City or Tour	State 7	n Code)
r trau			ill/ Grand						Drive, H			, Ototo, 24	0000)
othe	1	20e. Method of Disp	osttion		20b. Pt	lece of Dispo	sition (Neme	e of		Dete	20c. Location	- City or T	own, State
nry or			☐ Cremetion 3 ☐ F 5 ☐ Other (Specify)	Removel from State	9				Me.Cem	01-04-	Bear,	DE	
any Inj		21. Sig ware of Fu	eral Se ce	90		22	2. Name end	Addres	ss of Facility		Dear,	V.14	
5 6 9		10	AT Y			B 2	eeson 053 Pu	Mem las	orial Seki Hwy.	ervices Newark	, DE 19	702	
	1	23a. Part1. Enter th shock, or heer	ne diseese, or compl t feilure. List only or	ications thet cause ne ceuse on each	d the deeth line.								Approximate Intervel Between
ician dical	ı	Immediate Cause (F	Finel	Park	1,	1	. /	1,	NCER	0		1	Onset end Death
niner	4	disease or condition resulting in death)	1	1/CNI				-1-1	1/1/27			1	3 years
i i	ē				Due to (or	r es a consec	quence or):					1	
hal-transit	E	Sequentielly list con if eny, leading to imi	nditions,	), ————	Due to (or	es e consec	quence of):						
bunial E		cause. Enter Under Ceuse (Disease or I that initieted events	rlying Injury	ò								[	
edical Examin	3	resulting in death) L	ast		Due to (or	as a conseq	uenca of):						
To the Hundral breators Affective certificate has been signed by the effending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examin	2			d									
hed for	200	Pert ti, Other signific	cant conditions cor	ntributing to death I	out not resu	ilting in the u	nderlying ceu	use give	en in Pert I.	23b. Dio	tobacco use c	ontribute t	o the cause of deati
deteched										10	Yes 2□ No	3 Pro	bably 4 Onknow
id be del			-									T	e de visite de meneral
shoul	2010									24e. We	s an eutopsy formed?	av	fere autopsy findings relieble prior to empletion of cause
irector, page 2 should											-/	of	deeth?
e Co		25. Was case referre	ed to medical						00 81 ( 8-		Yes 2 No	1	☐ Yes 2☐ No
To B	ן כ	examiner?	-	fospitel:	ent 2 🗆 I	ER/Outpatier	nt 3 DOA	Othe	oc	eth (Check only	one) sidenca 6 □Ot	har (Snaci	60
neral		27. Menner of Deeth		28a. Date of Inj.	urv	28b. Time of		c. Injury Work		_	how injury occu		97
d in by the funera		1 Neturel 2 Accident	5 Pending Investigation	(ivioriii), D	, , , ,	anjuny	M		Yes 2 □ No				
Certification:		3 ☐ Sulcide 4 ☐ Homlcide	6 Could not be determined	28e. Plece of In building, e	jury - At hor tc. (Specify	me, ferm, str	eet, factory, o	office			(Street end Num own, Stete)	ber or Run	al Roufe Number,
		29e. Certifier	1 Dentifying Phys	eleten. To the heat	of my limous	dadaa daad		Ab a Alas					4.1.4
pletely fi		(Check only one)	1 ☐ Certifying Phys 2 ☐ Medical Examin	nar: On the basis of end menner si	of exemineti	ion end/or in	roccurred et vestigation, in	n my op	plnion, deeth occ	e, end due to the urred at the time	date end plece	enner as a , and due t	o the cause(s)
completely filled in		29b. Signature and ti	title of certific		A		29c. l	License	e number		29d. Date sign	ed (Month,	Day, Year)
		NIW	no S. hin i	ur M	7		D	00	53030	+	12/31	199	3
		30. Neme end eddre					Print)					, , ,	
		MARC	scheine	r M.D.	223	SW	WAIN	> <	T ELV	LTON	MD Z	921	
State		31. Dete filed (Month	h, Day, Yeer)		rer's Signet			,					
Registrar	1				UEU 3	1 199	8 4	Sen	wa	9 1	all.		

Registrar DHMH 16 Rev 6/95

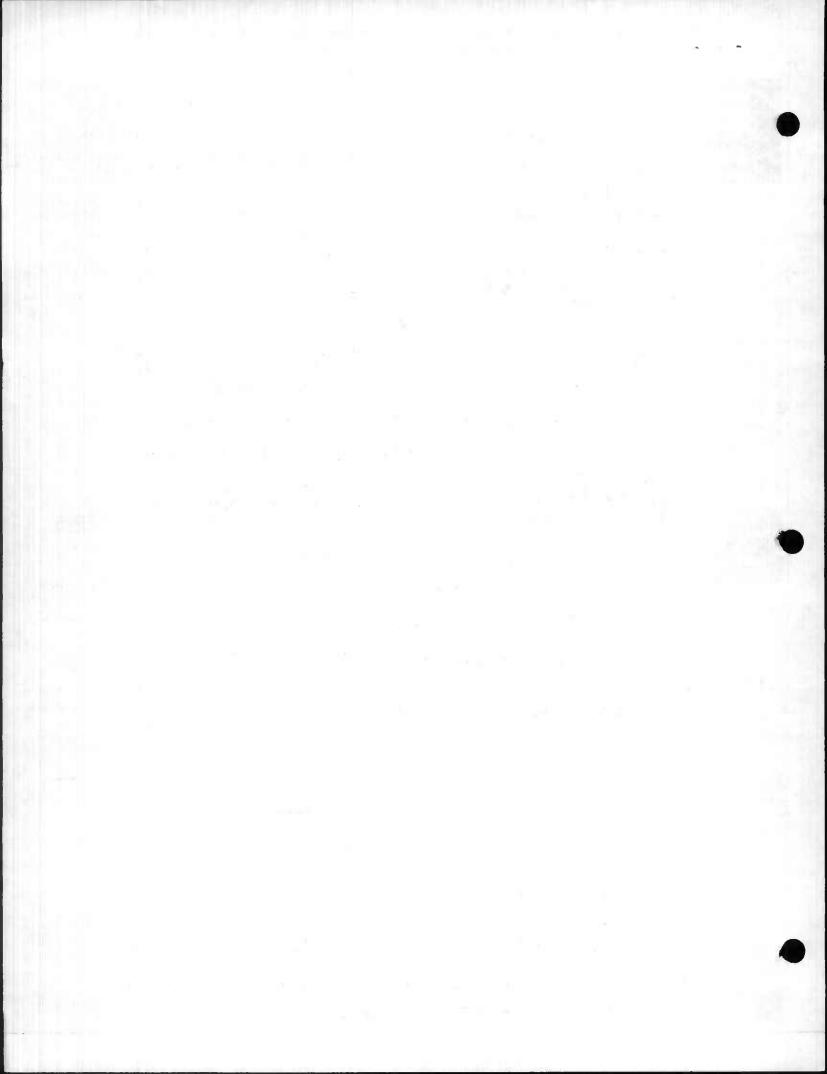


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State of Maryland / Department of Health and Mental Hygiene 98 4 14 0

		Decedent's Neme (First, Middle, L.	net)		Cel	tificate o	Death		Reg. No.		2 T12 "
Physicia	an			211-				2. Dete of De Month	Day	das	3. Time of Deeth 3:30 AM
/Medic	- 11			ills			4h Oh Taun a	Decembe			3:30 AM
Examine	er	4a. Facility Name (If not institution, gr Mallard Bay		oer)			4b. City, Town, or Cam	bridge		orche	ster
Funeral Pirector		The second secon	Sex 7 1 □ M 2 □ X F	Age (In yrs. lasi	birthday) Yrs.	If Under 1 Yes		6. Dete of Bir Month, De May 26	y, Year) 0, 1909	9. Birthpl Count Mar y	lace (State or Foreign try) (Land
ahow		10a. Stete 10b. County		10c. City, T	own or Lo	cation				10	0d. Inside City Limits
28a-f ah notified	ctor	Maryland Dorch	ester	C	ambri	idge					XX Yes 2□No
23a or 2	rai Director	10e. Street and Number 404 Cemetery Av	enue			10f. Zip Code 21 6			10g. Citizen of V		itry?
o.u	by Funeral	11. Marital Status  1 Never Married 2 Married  XXWidowed 4 Divorced	12. Wes Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? XNo		Was Decedent of Yes, specify Co	f Hispenic Origin? ( ban, Mexican, Pue o Specify:	Specify Yes or No to Rican, etc.)	Specifi	ck, White, e	
The Medical	Be Completed	15. Decedent's Elementery/Secondary (0-12)	ducation ade completed) College (1-4		(Give life. L	tent's Usual Occ kind of work dor DO NOT use reti	e during most of wo red)	orking	16b. Kind of B		dustry
ont, to	S	17. Fether's Name (First, Middle, Las	')		CI	au Fick	T	me (First, Middle			
7 la marked other t traumatic avent, m	To Be	Charles Abbott		18. Mother's Neme (First, Middle, Melden Sume Mary Jane Willey							
2 0		19a. Informant's Name/Relationship			9b. Meilin	g Address (Stre	et and Number or A	ural Route Numbe	er, City or Town,	Stete, Zip	Code)
om 27 ther tr		Lillie T. Warfi	eld Daug	ghter			d Street	-			
Important: If ite any Injury or ot once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [	Removal from St	ceme	itery, cren	sition (Name of natory or other p		Date	20c. Location -		
dury dury	28	4 Donation 5 □Other (Special		Sand	-	Land Cen		1/3/99	Robbins	s, Mar	ryland
any ir		21. Signeture of Funerei Service Lice			יוידי	Name end Add	noral Har	ne. P.A.			
sician		23a. Parti. Enter the disease, or conshock, or heert feilure. List only	pplications that cau	sed the deeth. C th line.	7( o not ente	OO Locus or the mode of d	st Street ying, such as cardie	Cambridg c or respiretory e	ge, Mary	land	21613 Approximate Interval Between Onset and Death
edical miner		Immediate Cause (Final disease or condition resulting in death)	a. 3/P	4 ten	rpe	ropa	rietal	she	she	1	ueus
-	ner		6	egall			۷.			1	jeens.
trans	Examiner	Sequentially list conditions,	b. ———	Due to (or es	-						jeers.
yan a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		yper	ins	non	•				year
g physician and es the buriel-transit	edicai	that initiated eventuresulting in death) Last	G.	Due to (or as	-						
	Me		· Assuration burnous.								rung
attendir for use	clan										
ned by the attending deteched for use	by Physician/M	Part II. Other eignificant conditions  Election		*		aderlying cause		23b. Did 1	1		the cause of deeth?
2 should	Completed								an autopsy rmed?	ava	ore autopsy findings alleble prior to appletion of cause death?
is certificate he director, page	5							101	res 2000	1 🗆	Yes 20 No
ertific actor.	Be	25. Wes case referred to medical exeminer?	112-21					eth (Check only o	ne)		
5 70	n: To	1 ☐ Yes 2 No. 27. Menner of Death	Hospital: 1 Inp 28a. Dete of (Month,		. Time of	1 3□ DOA C 28c. In		dome 5 Resid	denca 6 Oth	1-1-1-7	)
r: Aft	atio	1 ☐ Natural 5 ☐ Pending investigation	n	Day Year)	Injury		ork? ⊒Yes 2⊡No				
d in by th	Certification:	3 Suicide 6 Could not 1 determined	286. Place of	injury - At home , etc. (Specify)	ferm, stre	et, fectory, offic	â.	28f. Location (5 City or Tox	Street end Numb vn, Stete)	er or Rural	Route Number,
ha Funer pletely fill	edicai	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exa	ysician: To the be niner: On the basi and menne	s of exemination	lge, deeth end/or inv	occurred at the restigation, in my	time, date and plece opinion, deeth occi	s, and due to the urred at the time,	cause(s) end me date and place,	anner es sto and due to	ated. the cause(s)
Com	Σ	29b. Signeture end title of pertifier					nse number		29d. Dete signe	d (Month, E	Day, Year)
		1/2				D.	50987		14/31/	98	
		30. Name and address of person who	completed cause				et Cambrio	lae Mari	vland 21	613	

State Registrar



1. Decedent's Neme (First, Middle, Last), 2. Dete of Deeth Mockins Month 2 **Physician** Willie /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Dorchester General Hospital Dorchester Cambridge 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth 9. Birthplece (Stete or For Sept. 22, 1910 Maryland 6. Sex 1 M 2 F 9. Birthplece (Stete or Foreign 。Funeral Months Deys Hours 217-16-9245 Yrs 88 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location Show an "natural", or items 23a or 28a-f show Director Maryland Dorchester Fishing Creek 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21634 U.S.A. 1220 Horse Point Road items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 21215-0020 Bleck, White, etc 1 XYes 2 No Il Yes, Give Yeer or Detes: 1 Never Merried 2 Married natural, or 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced WWII Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Shellfish Waterman Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be permit. Pagas 1 and 2 should be f Department of Heelth and Mental I Important: If item 27 is marked or any Injury or other traumatic eve Alfred Meekins Octavia Parks 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rt. l, Box 214 C, Laurel, DE 19956 19a. Informant's Name/Relationship (Type, Print) Calvin W. Meekins/Son 20b. Pleca ol Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-31 Hurlock, MD MD Veterans Cemetery 22. Neme end Address of Fecility
Curran-Bromwell Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, April 200 and 100 and 100 and 100 and 100 arrest. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumonia **Examiner** Due to (or es e consequence of) Physician/Medical Examir sician and bunial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or es e consequence ol): tha Due to (or as a consequence of)

The law requires that the death certificate be axecuted meekins, w, the paga 2 Division of Vital Physician: this Ne Hospital or Attending Pin 24 hours after death.

Completed

Be

Certification: To

Medical

After

To the Hosp within 24 hor To the Fune complately fi

in by

25. Wes case referred to medical examiner?

1 Yes 2 No

27. Menner of Death

2 ☐ Accident

3 Suicide

4 - Homicide

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Viganic

23b. Did tobacco use contributa to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes

24e. Wes an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes

1 ☐ Yes 2 ☐ No

Approximete Interval Between Onset and Deeth

3. Time of Deeth

10d. Inside City Limits

White

1 ☐ Yes 2 No

8.30 pm

28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

214349

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

12-28-98

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

С Сашиан

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Hospitei:

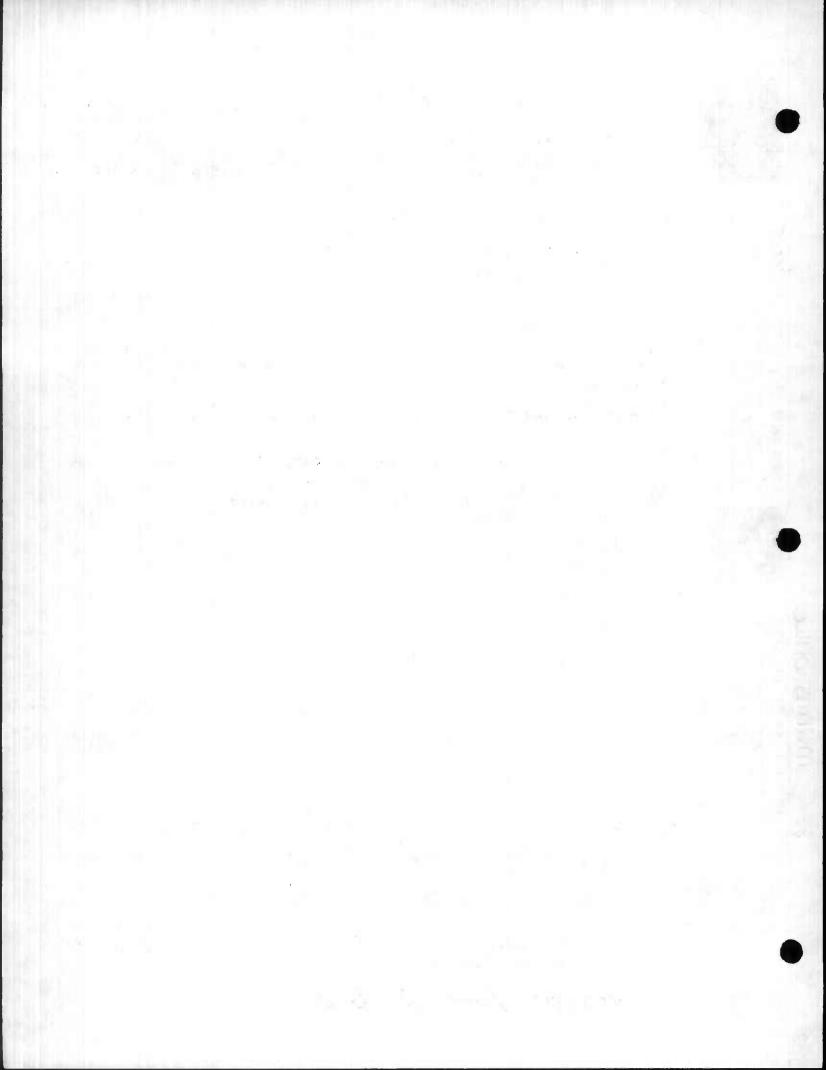
5 Pending investigation

6 Could not be determined

State Registrar

Eyup Tanman, M.D., 15 Franklin Street, Cambridge, Md. 21613

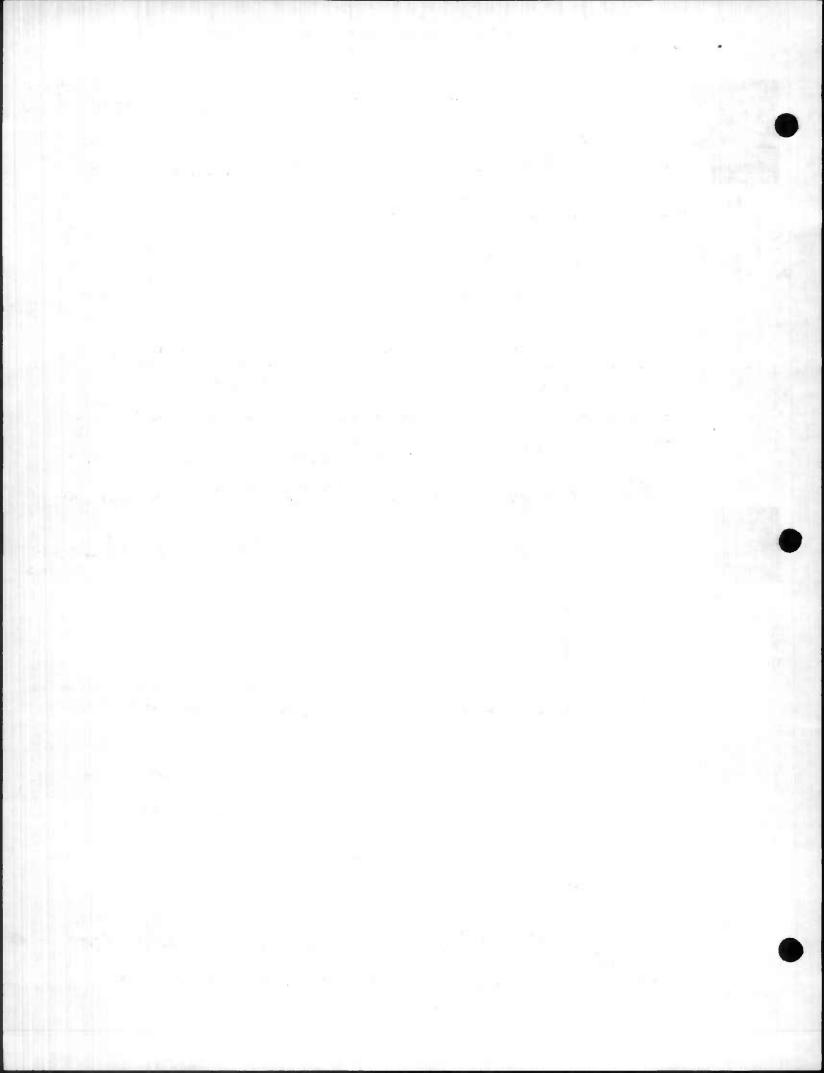
10 1998 32. Redistrar's Signature 9. Apouls



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State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate	of	Death			Reg. ?	No.		
Physician		Decedent's Name (First, Mid	die, Last	•	RT	CHARD		MARYA	NO	J.		2. Date of D Month	eath [	Day	Year	3. Time of Death
/Medical Examiner		la. Facility Name (If not Instituti	on, give	street and nu	mber)	Ommo		1111111		4b. City, To		Decembocation of Dea	th 4	c. County		0500
uneral		300 Son	_	et Ave X OM 2□F	7. Age (	'In yrs. last birth		If Under	Year Davs		oride 24 Hrs. Min.	8. Date of Bi (Month, D Dec 2			9. Birthp	iaca (State or Foreic
irector		220-10-8009 Usual Residence of Decedent	AL	UM ZUF	85	Υ	rs.					Dec 2	,191	13	New	York
-f show		Maryland Dorc		er	1	Oc. City, Town					(%)				1	0d. Inside City Limit XX Yes 2□N
or 28a-f s be notified Director		Ioe. Street and Number						10f. Zip	Code				10g. (	Citizen of \	What Cour	itry?
		300 Som	erse	et Aven	iue				216	13				US		
al, or items 234 Examiner must by Funeral		1. Marital Status  1. Never Married 2. Ma 3. Widowed 4. Divorce	-	12. Wes Dec Armed Fo 1 X Yes If Yes, Giv Year or D	orces? 2 No ve /		It	Vas Decede Yes, speci	fy Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	0-		ce - Americ ck, White, y: Wh	
T, I'm Medical		15. Decade (Specify only high Elementary/Secondary (0-12)	nt's Edu est grad	le compieted) College (	1-4or 5+)	-	Give k iife. D	OO NOT us	done retire	during mos d)	st of work	ing			usiness/Ind	dustry
Se Co	3	12 17. Father's Neme (First, Middle	Lasti	5+		1	led:	ical	Doc		ar's Nam	e (First, Middle		alth		
matic even		Harry Marya	nov									Melin		Err Odirian	147	
2 2	- 1	19a. Informant's Name/Relation Mary D. Maryan		ире, Print) Wife				_				ai Route Numl ambrid				
nt: If item 27 ry or other tr	1	0a. Method of Disposition  1.XXXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (			State	20b. Placa of I cametery Old Tr	, cram	atory or of	ner pia		1	Date 2/31/98			Cree	
important: if if any injury or o	-	21. Signature of Euneral Service				Shi	22. T	Name and	Addre	ess of Facili	ty Hom	e, P.A				1 21613
is the burial-transit and the burial-transit and the burial-transit and the burial-transit and the burial transit and transit and the burial transit and the bur		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, f any, leading to immediate ausa. Entar Underlying Cause Disease or injury hat innitated events resulting in death) Last	{	, HR	Du	e to (or as a co	ensequ	uenca of):		- Dr. 6	10 1	Bou	CAR	- B &	SASE	Secret  VIAN
be detached for use as it	-	Part II. Other eignificant condit	lons cor	d	- 4	not resulting in		1		ven in Part	i.					the cause of death
2 should												24a. Was	s an au ormed?	topsy	ev.	ere autopsy findings allable prior to mpletion of cause death?
certificate has rector, page 2.												10	Yes	2 D No	10	Yes 2□No
director,		25. Was case reterred to medic examiner?		lospital:					04	26. Place	of Deat	h (Check only	one)			
by the funeral di		3 ☐ Suicide 6 ☐ Could	ing tigation	28e. Date (Moni	of Injury	28b. Tie	me of ury	M 28	c. Inju Wo 1	4 LI NI		28d. Describe	how in	jury occur	red	y) ii Route Number,
To the Funeral Dir completely filled in Medical Cert		29a. Certifier 1 Certify	ng Phys	sician: To tha	asis ot ex	ny knowledga, amination and/	daath or inva	occurred a	t tha ti	ma, date ar	nd place, ith occur	City or To	causa	(s) and ma	anner as st	ated.
To the comple		29b. Signature end title of cartifi	er }	and mani	LI STATE	l_		29c.	Licens	se number	6 =	2	29d. [	Date signe	d (Month,	Day, Year)
		0. Name and address of person  Mahmood Sha	rif	f, M.	D.	105 Au			tr	eet (	Camb	ridge	, M	D 21	613	
State Registrar	3	11. Date tiled (Month, Day, Year  DEC	-	1998 D	- /	Signature	13	1. p	00	els						



#### Please Ty

pe or Print in Black Indelible Ink. Assure	All Copies Are Legible.	
State of Maryland / Department of Health and	Mental Hygiene	1443
Certificate of Death	Reg. No.	
	2. Dete of Deeth	3. Time of Dea

**Physician** /Medical Examiner

1. Decedent's Neme (First, Middle, Last)

29d. Date signed (Month, Dey, Year)

**Funeral** 

Director

item 27 is marked other than "naturel", or items 23a or 28a-f show other traumede event, the Modical Examinar must be notified at permit. Pages 1 end 2 should be filed within 7. Depertment of Heelth end Mental Hyglene. Important: If item 27 is marked other than "ne eny injury or other traumatic event, the Media once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

The lew requires that the death certificate be executed buriel-transit end attending physician for use es the burie Box 68760 the 98 signed by the aid be detached for Records, P.O. been si pege 2 s certificate Division of Vital Hospital or Attending Physician: 24 hours efter deeth.
Funeral Director: After this certifica director. After this funeral c in by • Funeral Di

DECEMBER 26, 1998 10:50PM EDWARD THOMAS MOXEY, SR. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 3822 WANEX ROAD EAST NEW MARKET DORCHESTER If Under 1 Year | if Under 24 Hrs. Months Deys Hours Min. 6. Sex 1 ☑ M 2 ☐ F 5. Sociel Security Number Birthplece (State or Foreign Country)
 MARYLAND 7. Age (in yrs. iest birthday) 8. Dete of Birth (Month, Dev. Year) MARCH 6, 1927 218-20-7445 71 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND DORCHESTER EAST NEW MARKET 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3822 WANEX ROAD 21631 USA Funeral 12. Wes Decedent Ever in U,S. Agned Forces? 1 Pyes 2 □ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. 11 Merital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 10 AUTOMOBILE BODY REPAIR AUTOMOBILE DEALERSHIP 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be JOSEPH NATHANIEL MOXEY MARY KATHERINE LAUCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MAYBELLE M. MOXEY/WIFE 3822 WANEX ROAD, EAST NEW MARKET, MARYLAND 21631 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 12 Burial 2 ☐ Cremation 3 ☐ Removal from State OUR LADY OF GOOD COUNSEL 12/30 4 ☐ Donation 5 ☐ Other (Specify) SECRETARY, MARYLAND 21. Signeture of unerel Sep 22. Name end Address of Fecility
ZELLER FUNERAL HOME, 106 MAIN STREET, en P.O. BOX 207, EAST NEW MARKET, MD 21631 232 Parl. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel Bron diojanic 1:14onla disease or condition resulting in deeth) Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Pert II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturei 5 Pending Investigation 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

State Registrar

Medical pletely

29e. Certifler (Check only one)

29b. Signeture and title of cartifier

GIZANADA MD MAIZICJ. 31. Dete filed (Month, Dey, Year) **DEC 3 0 1998** 

alle

5 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

Box 913 SEALEURD

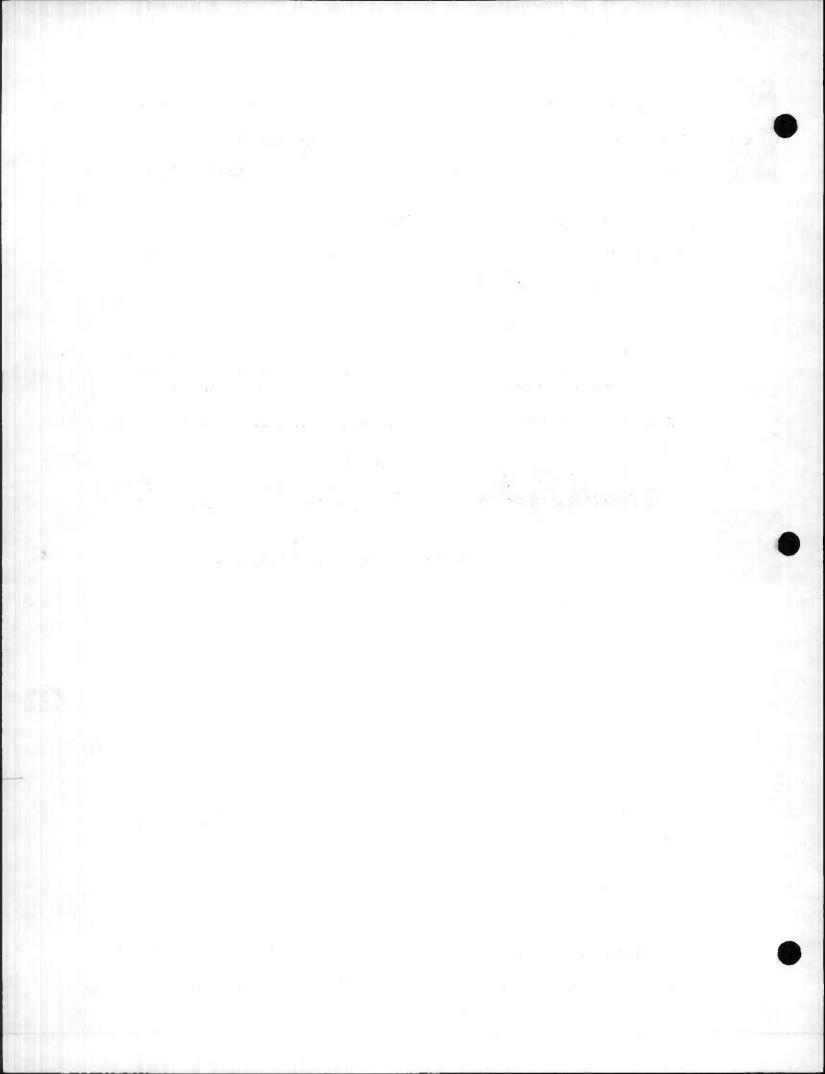
1 🗹 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

C1000/675

To the I within 2 To the I



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician JEROME** D. NILES. JR. 3:20pm Dec. 29 1998 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9707 Old Georgetown Rd. Apt. # 2508 Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** 10 M 20 F Months Director 84 10-7-1914 202-07-9495 Delaware Usual Residence of Decede death with the Maryland 10a. State -10b. County 10c. City. Town or Location 10d. inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 No Yes 2 No Md. Montgomery Bethesda 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 2508 9707 Old Georgetown Rd. Apt. # USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Insportant: if frem 27 is marked other than "natural", or free any injury or other traumatic auch. Black, Whita, atc. N Yes 2 No
If Yas, Give
Year or Datas: 44 - 74 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas X☐ No Specify: Specify: white à 3€Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Guard Elementary/Secondary (0-12) College (1-4or 5+) US Public Health Service Delaware National 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be Jerome D. Niles, Sr. Marjarett Madden Loretta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Tansey 2823-29th Street N.W., Washington, DC 20008 20b. Placa of Disposition (Name of cemetery, crematory or othar placa) 20a, Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-31-98 Dover, DELAWARE Capitol Cremation 21. Signature of Funaral Sarvice Licens DANTELS "HUTCHISON FUNERAL HOME 212 N. Broad St., Middletown, DE. 23a. Part1. Entar tha disease, or complications that caused the death. shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Final disaasa or condition resulting in death) Examiner a consequence of) (Metastatic Lung Cancer) slcian and burial-transit Sequentially list conditions, if any, laading to immediata cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burie P.O. Box 68760. certificate be Physician/Medical Due to (or as a consequence of): ed by the a detached f Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b Records. p been si 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed has certificata 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funaral director, 25. Was case referred to medical examiner? 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5X Residenca 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. injury at Work? Certification: 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Naturai 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be datarmined 3 Suicida 28e. Piaca of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier 🎦 Certifying Physician: To the best of my knowledga, death occurrad at the time, date and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mann 29b. Signature and title of cartifier 29c. License number 29d. Data signed (Month, Day, Year) 20+ 30. Nama and address of person who come d cause of death (Itam 23a) (Type, Print)

State Registrar

JAN 0 4 1999

31. Date filed (Month, Day, Year)

Fred P. Smith

Day, Year)

1999

Separate

ith 5401 Western Av., Washington, DC20015-2998

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month FRANCIS PERRY DECEMBER 28,1998 10:15AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 7. Aga (In yrs. last birthday) H Undar 1 Yaar if Undar 24 Hra. 8. Date of Birth (Month, Day, Year) (Country) MARCH 4, 1998 MARYLAND 6. Sex 1 → M 2 □ F 5. Social Security Number 9. Birthpiaca (Stata or Foreign 213-22-7450 Usual Residence of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inalde City Limits 1 XYaa 2 □ No MARYLAND QUEEN ANNE CENTREVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21617 205 ARMSTRONG AVENUE USA 12. Waa Decedent Ever in U.S. Armed Forcaa? 1 ⊠Yes 2 □ No If Yes, Give Yaar or Dataa: 1944 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American indian, Black, White, etc. 11. Maritai Statua 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grads completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Induatry Elemantary/Secondary (0-12) College (1-4or 5+) FARMHAND 10 AGRICULTURE 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) EMMETT CHARLES PERRY EVA CHAMBERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addraas (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA KILLOUGH/NIECE P. O. BOX 3, HURLOCK, MARYLAND 21643 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VET. CEM. EASTERNSHORE 12/30 BEULAH, MARYLAND 21. Signature of Funaral Sarvice Close ee 22. Name and Address of Facility
ZELLER FUNERAL HOME, 106 MAIN STREET, P.O. BOX 207, EAST NEW MARKET, MARYLAND 21631 23a. Part . Enter the disease, or shock, or heart failura. List ii ti n t/at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, u on each lina. Approximate Interval Between Onset and Death Immediate Cause (Final disaasa or condition resulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did topicco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 ☐ Unknown 24b. Were sutopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 PNo 1 Yaa 2 No 25. Was casa referred to medical axaminar? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Hospital: 1 Yes 2 No 1 inpatiant 2 ER/Outpatient 3 DOA 27. Manper of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Naturai 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner Box 68760, P.O. | Records, Division of Vital

physician and the burial-transit The law requires that the death certificate be axecuted signed by cartificata Physician: After this To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director; After th completaly filled in by the funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If them 27 is marked other than "n any injury or other traumatic event, the Med obtes.

**Physician** /Medical

Physician/Medical

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Completed

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Certification: To

edicai

29a, Certifier

Baltimore, Maryland 21215-0020

Director

Funerai

by

Completed

State Registrar

JAN 04 1999

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner attated. 29d. Data signed (Month, Day, Year)

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f	Maryland /	Department	of Health and	Mental Hygi	ene d	13	44	6

Physician	
/Medical	
Examiner	

**Funeral** 

**Director** 

Director

Funeral

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than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentai Hygiene. Important: if frem 27 is marked other than "natural", or the any highry or other traumatic event, the Medical Frams and bother.

Examiner Physician/Medical by Completed page 2 s Medical Certification: To Be

Baltimore, Maryland 21215-0020 **Physician** /Medical **Examiner** iclan and burial-transit The law requires that the death certificate be executed physician the burial Box 68760. P.O. Division of Vital Records, or Attending Physician: After this death. Birector: filled in by To the Hospital o within 24 hours af To the Funeral Di completely filled in

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 31, 1998 0430 Rena Austin Phillips 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil Laurelwood Continuing Care Center Elkton | Months | Days | Hours | Min | Feb ruary 11, 1920 | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | Plank | P 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□ M 25 F 78 Yrs. 211-20-4520 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Cecil Elkton 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 100 Laurel Drive 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 🔀 No 1 Never Merried 2 Merried 1 ☐ Yes 2 ₩ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Leslie Sartin Grace Heverin 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet Meyer/ Daughter P.O. Box 183, Kenneth Square, Delaware 19348 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State January 4, 4 ☐ Donation 5 ☐ Other (Specify) 1999 Hickory Grove Cemetery Port Penn, Delaware 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 uks huse H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Serile Dementia of Alzleiner's Type
Due to (or as a consequence of): 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending Investigation 6 Could not be determined

28a. Dete of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier Monte Makous,

D 44783

29c. License number

29d. Dete signed (Month, Day, Year) Descenher 31,1998

ELKTON, MD 21921

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

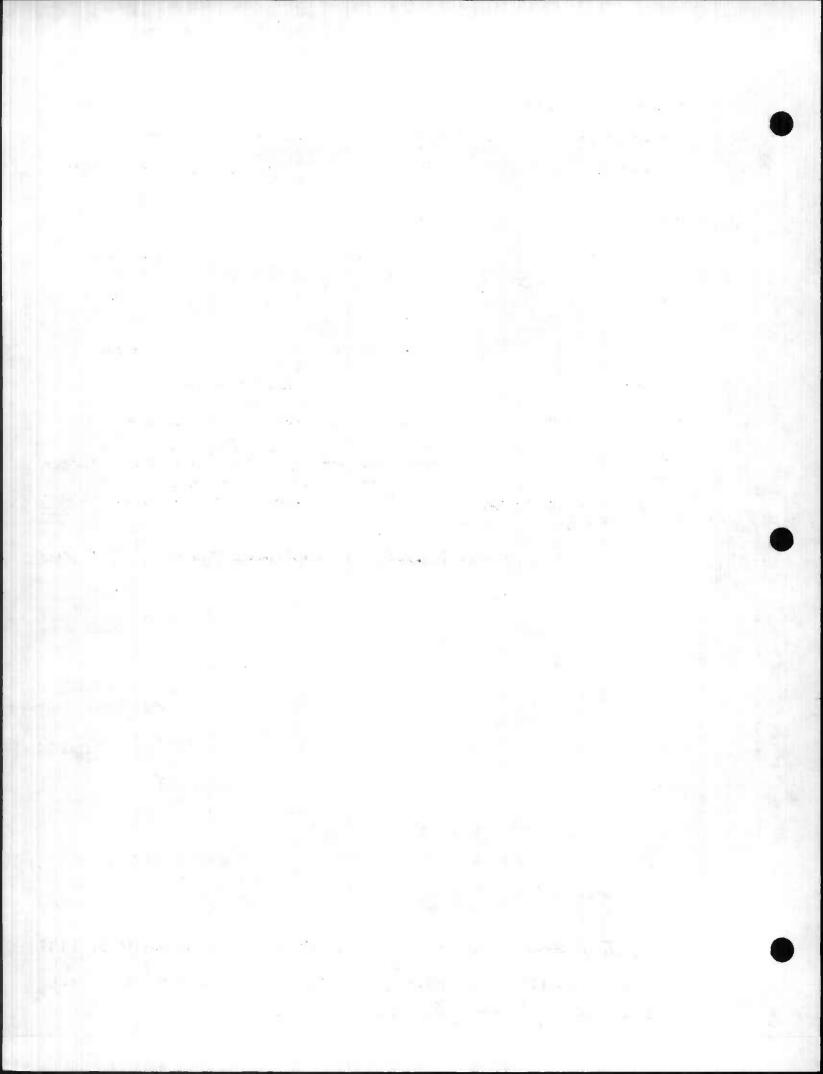
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JAN 0 4 1999

WEST 111 32. Registrar's Signature

HIGH STREET

State Registrar



Division of Vital Records, P.O. Box 68760, or Attending Physician:

physician and s the burial-trans 88 esn ed by the a be del page 2 funeral director, After this after death. filled in by 24 hours a Hospital To the Hosp within 24 ho To the Fune completaly fi

**Physician** 

/Medical

Examiner

Directo

Funeral

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinat must be notified at

"natural"

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**Physician** /Medicai

Examiner

Examiner

Physician/Medical

by

Completed

Certification: To

Medical

29a. Certifier

(Check only one)

the Maryland

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filed within 72 hours after

Baltimore, Maryland 21215-0020

State

Registrar

harles 31. Dete filed (Month, Dey, Year)

29b. Signature and title of certifier

B. Silvia Jr 32. Registrer's Signeture

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

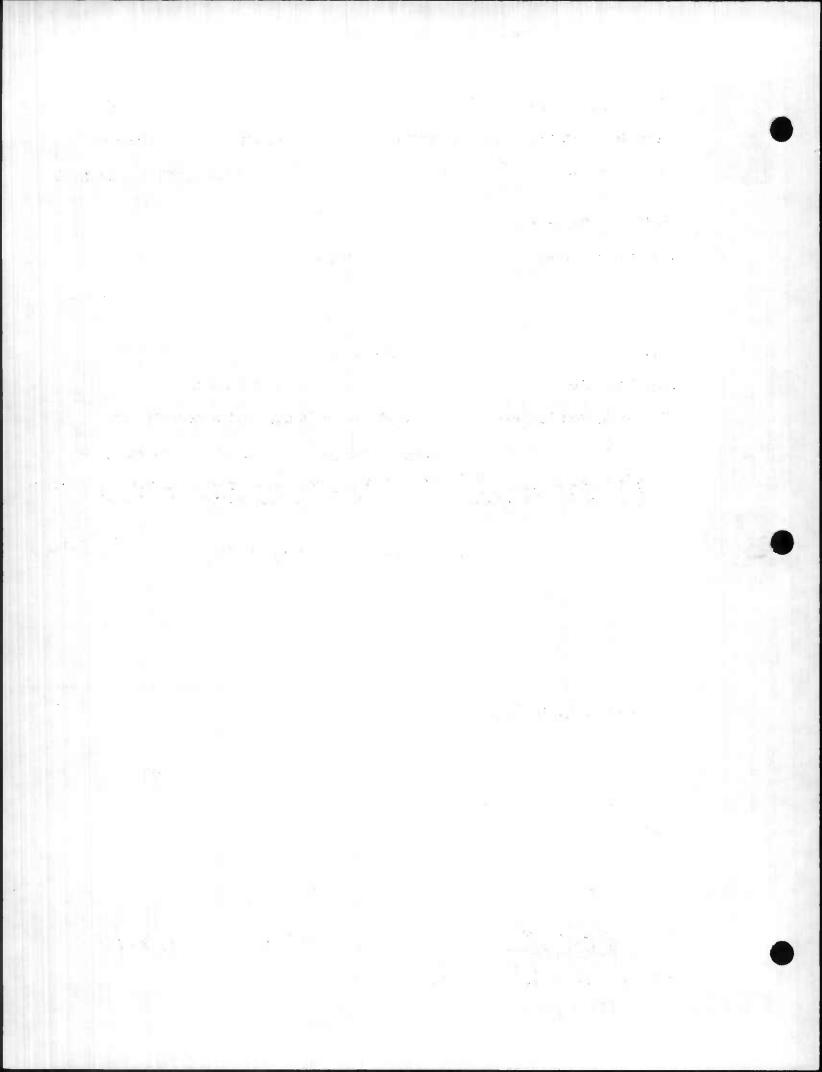
29c. License number

D30853

29d. Date signed (Month, Day, Year)

DEC 3 0 1998

30. Name end address of person who completed ceuse of deeth (item 23e) (Type, Print)



The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician:

physician and the bunal-transit 88 980 ŏ signed by the a been sign is certificate has b this After this efter death. Director: / 24 hours effer Funeral Dire letely filled in b within 2 To the f

**Physician** 

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Pages 1 end 2 should be filed within 72 hours efter deeth with the Merylen neat of Health and Mertal Hyglene.
Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show any or other than the point is any or other traumatic evant, the leading Exercites must be notified as

permit. Page Department of Important: If I any Injury or once.

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Certification:

Baltimore, Maryland 21215-0020

State

Registra

MONTE MAKOUS 31. Date filed (Month, Day, Year) JAN 0 4 1999

Monte Malous, MD

29b. Signature and title of certifier





29c. License number 29d. Date signed (Month, Day, Year)

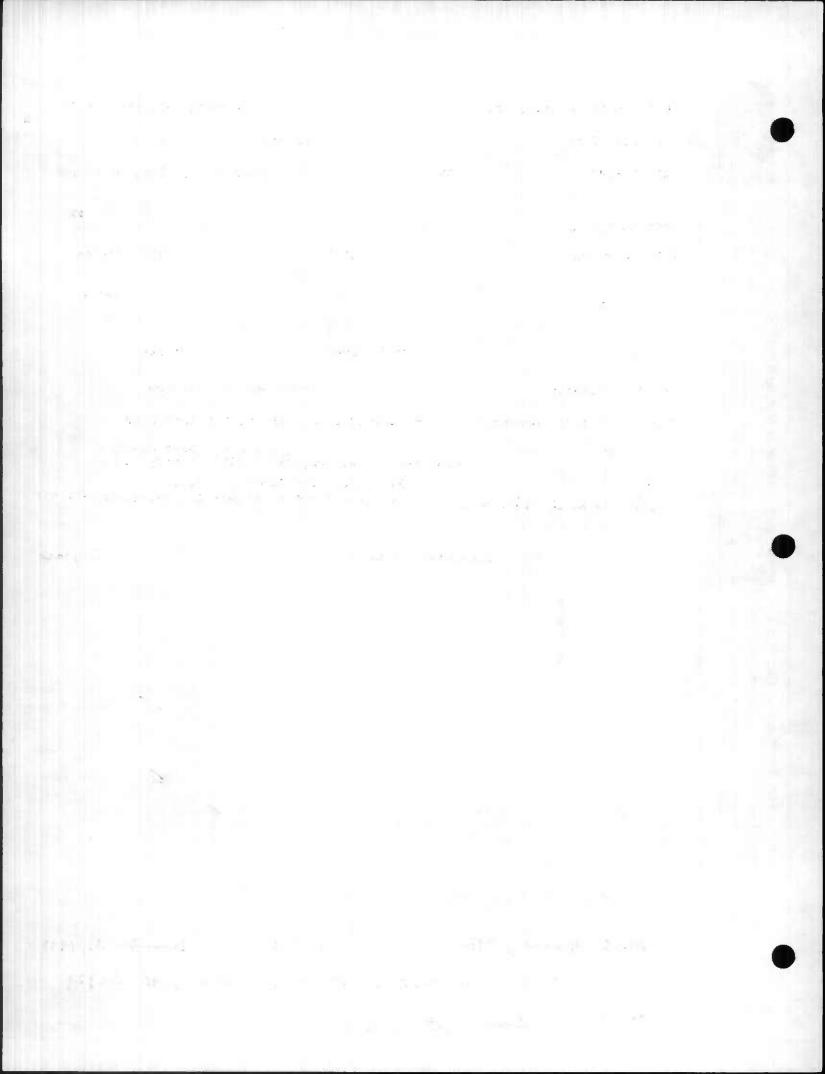
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December 31, 1998

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

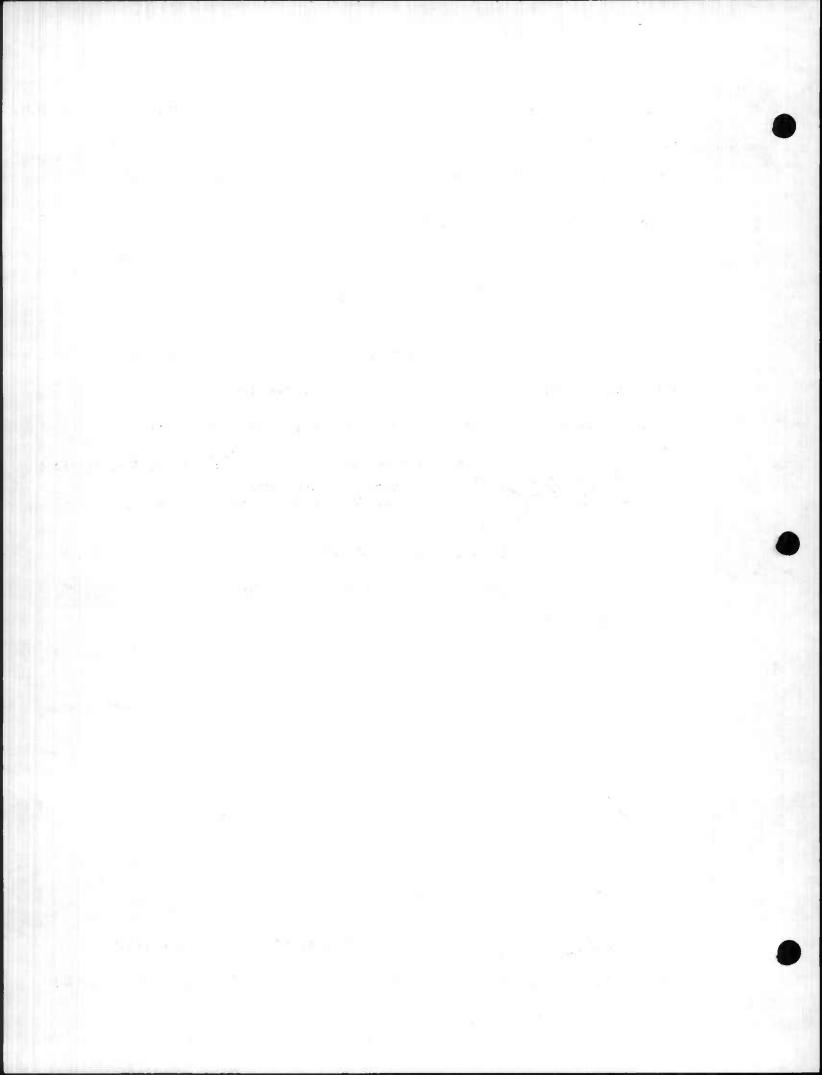
Ill West High Street, Elkton, MD 21921

**DHMH 16 Rsv 6/95** 



Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Fred Elmer South December 29, 1998 0105 /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death Examiner Sunrise Care and Rehabilitation Elkton Cecil If Undar 1 Year 8. Data of Birth 9. Birthplaca (St. (Month, Day, Year)
March 5, 1928 Kentucky 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. 6 Sex Birthplaca (State or Foraign Country) **Funeral** 1 M 2 F Months Deys Hours Min. 70 Yrs. 169-22-8252 Director Usuai Rasidanca of Decedant Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Heelth and Mental Hygiene. Int: If Hem 27 Is marked other than "natural", or Hems 23a or 28a-f ahow Iry or other traumetic event, he Medical Exam her must be notified at 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yes 2 ☑ No Maryland Cecil Directo Elkton 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2823 Singerly Road 21921 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yas, Giva Yeer or Dates: 14. Race - Amarican Indien, Black, Whita, atc. 13. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 □ Nevar Married 2 □ Married 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) University of Elamantary/Secondary (0-12) College (1-4or 5+) Delaware Custodian 10 18. Mothar's Neme (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Tobe South Aughtha Sexton 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Ralationship (Type, Print) Freda M. Spence/ Sister 2823 Singerly Road, Elkton, Maryland 21921 20b. Placa of Disposition (Nama of cametery, crematory or other place)
Cherry Hill 20e. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata Department of Important: If any Injury or page. December 31, 4 ☐ Donation 5 ☐ Othar (Specify) Methodist Cemetery 1998 Cherry Hill, Maryland 21. Signature of Funeral S e Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 entented the diseas, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. The mode of dying acause on sech line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Finel U7445 SEDTICEMIA diseasa or condition resulting in daath) Examiner Dua to (or as e consequence of): Examiner PNEUMONIA 1 won My physician and the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Diseese or injury that initieted events rasulting in daeth) Lest Dua to (or as a consaquanca of): 1 West TH DECUBITUS ULCER Physician/Medical Dua to (or as a consequanca of): 98 10 40728 CENERWURS WITH ALLIDENT 980 signed by the a d be deteched f 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 24 No 3 Probably 4 Unknown Completed by 24b. Wara eutopsy findings available prior to completion of cause of daath? 24a. Was an eutopsy performed? page 2 2000 1 □ Vas 1 Tyas 2 No certificate Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifica director, 25. Wes casa rafarrad to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. injury at Work? Certification: 28b. Tima of 28d. Describe how injury occurred 1 ENatural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 3 Suicida 6 Could not be datarmined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To tha best of my knowledge, deeth occurred et the tima, deta and placa, and dua to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of axaminetion and/or invastigetion, in my opinion, deeth occurred et the time, date end placa, end dua to the causa(s) and menner steted. 29c. Licansa number 29d. Dete signed (Month, Day, Year) 29b. Signetura and titla of certifier Inlunde legist. 007463 12-29-98

State Registrar

31. Deta filed (Month, Day, Yaar)

DEC 3 0 1998

Rolando Najera M.D.

30. Nama and addrass of person who complated causa of death (Itam 23e) (Type, Print)

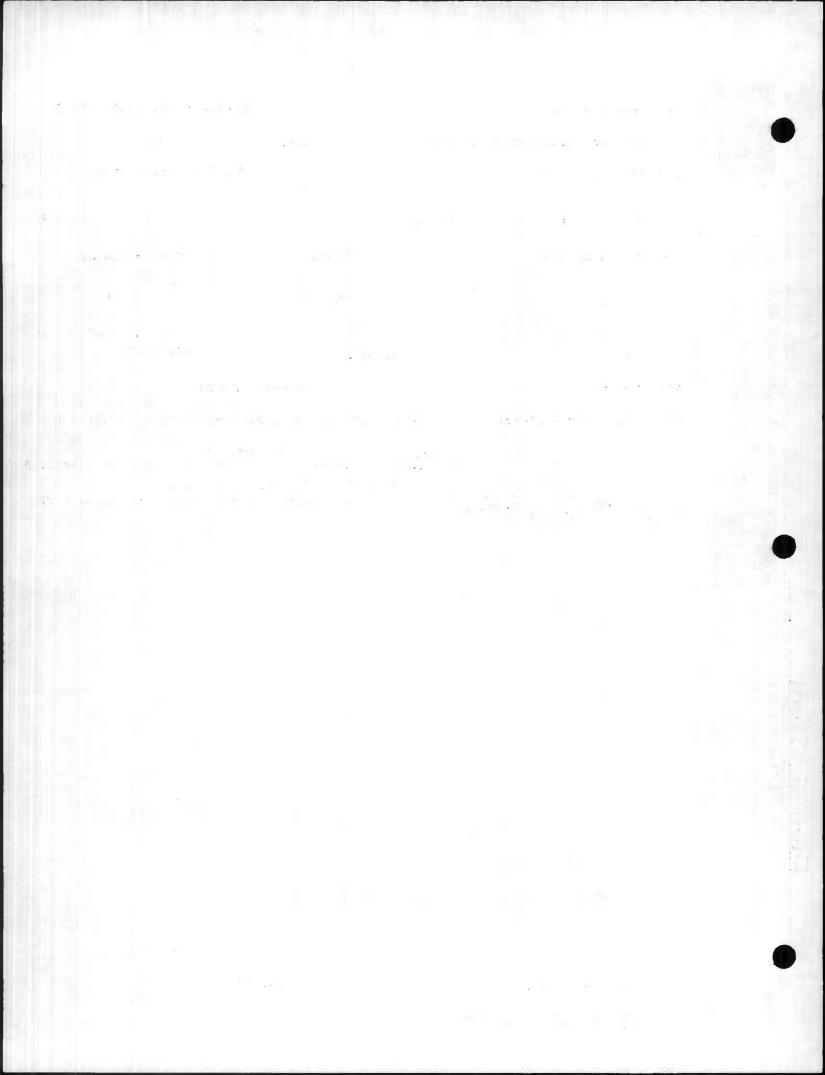
32. Ragistrar's Signetura

111 West High Street, Elkton, Maryland 21921

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vitai Records, P.O. Box 68760,

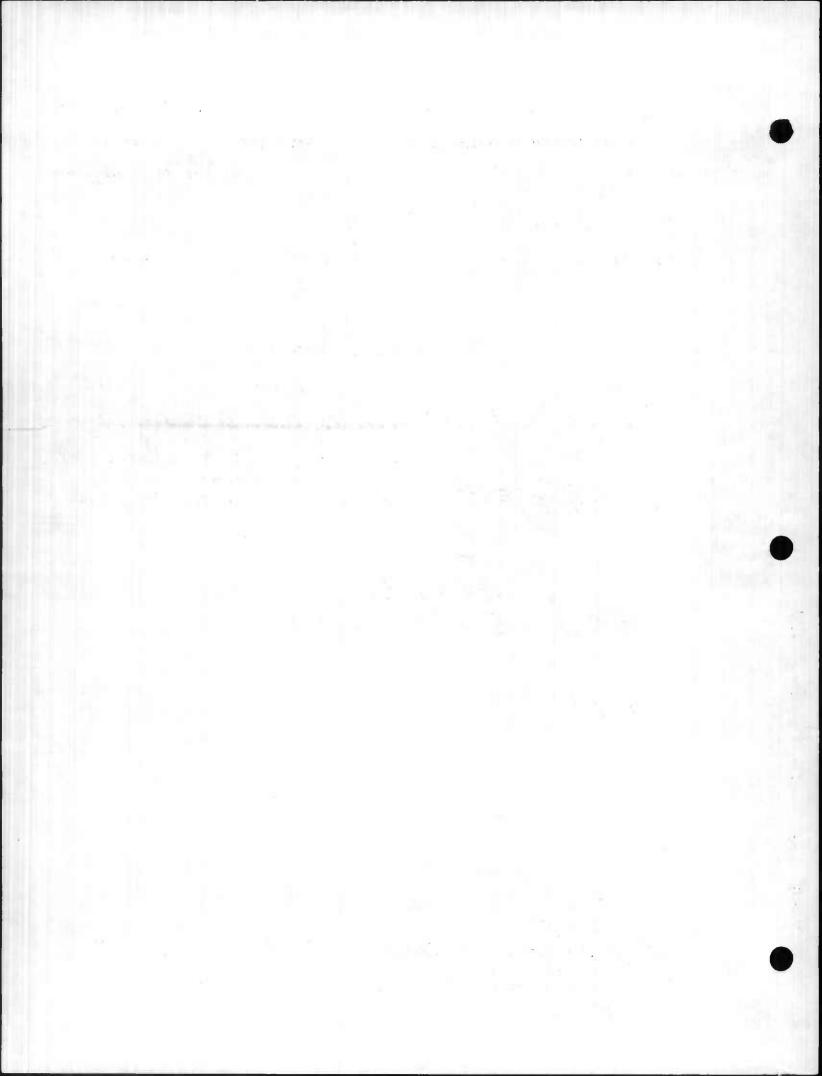


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 1) orthy CI Decembra 1320 /Medical 4a Facility Name (If no institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth Month, Day, Year, Birthplace (State or Foreign Country) Days **Funeral** 1 M 2 L Months 8% 215-18-1893 VIZZINIA Director Usual Residence of Decedent the Maryland 10d. fnside City Limits 10a State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mantal Hygiene, it is famed of the arracted duber than "natural", or frem 23a or 28e-f eho mit yor other treamstic event, the Masses Examine must be notitled at my or other treamstic event, the Masses Examine must be notitled at SHISBAL 1 ☐ Yes 2 ☐ NO Director 108 MIC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21861 454 6 Funeral 12. Wes Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 Ne Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) INVESTIGATION 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Goodie GoodE AJES LAKA POLES 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 192 Informant's Name/Relationship (Type, Print) Smith CABIN Pd. SHISBARC Mde JHOM45 Husband 20b. Placa of Disposition (Neme of cemetery, cremetery or other ple 20c. Location - City or Town, State 20e. Method of Disposition Date Department of Important: If is any Injury or o 1 Deturial 2 Cremetion 3 Removal from State Charter Albatas 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SCEAN Mode 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset and Death respiratory arrest Physician /Medical Immediete Cause (Finel disease or condition resulting in deeth) **Examiner** physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 2 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s After this certificate has funeral director, page 2 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Be To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Panpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5-18-1893 1 Natural 5 Pending 1 Yes investigation 2 Accident after death 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide A 24 hours P 19 Certifying Physicfan: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) end manner as stated.

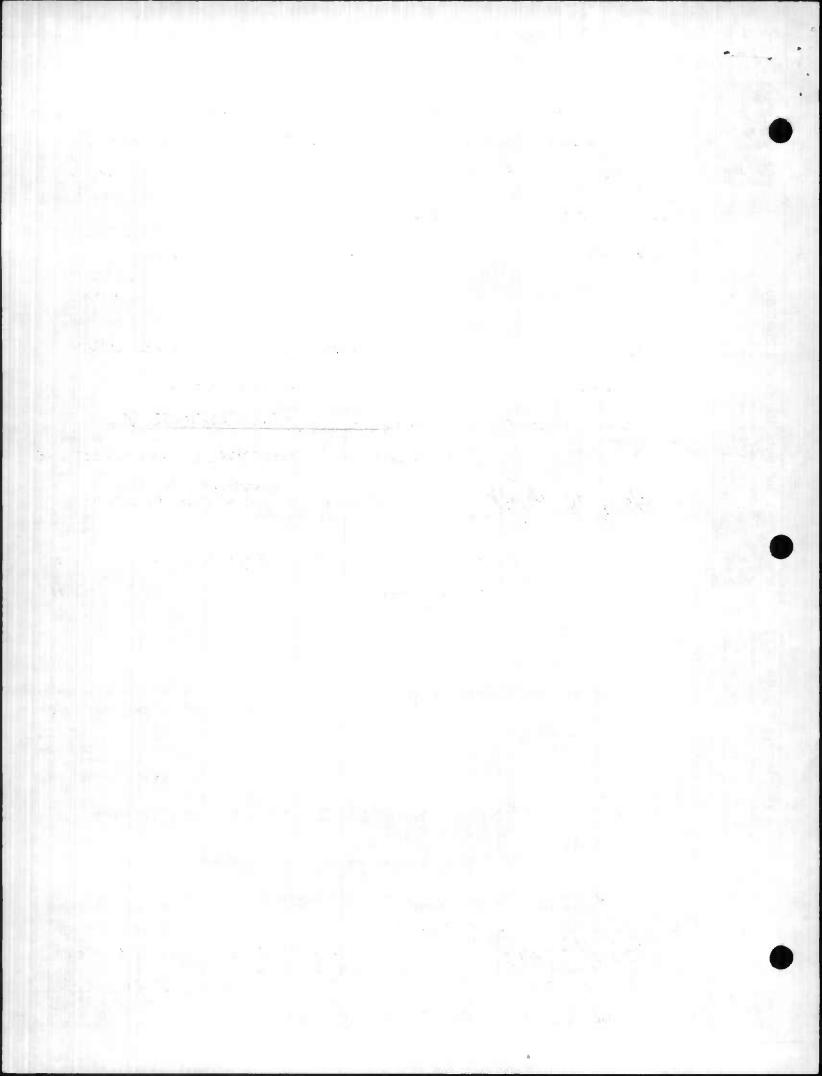
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completaly fi Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person wind completed cause of death (Item 23a) (Type, Print) 5 werside DEC 3 32. Registrar's Signature State 0 1998 Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #19b, per F.D. 12/23/98, Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** 930 21 1998 Dec DUSanne /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore City University Hospital Baltimore 8. Dete of Birth (Month, Dev. Year)
Oct. 12, 1959 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 □ M 2 1 F Yrs. 216 80 9057 39 Maryland Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Examenar must be notified at Md. Carroll Eldersburg 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 631 Fern Way 21784 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Stetus Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2000 Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If flem 27 is marked other than "I ury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event, Its Menury or other traumatic event e Elementery/Secondary (0-12) College (1-4or 5+) Lawyer Office Office Assistant 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Catherine McGourn Jack McGehrin 19e. Informant's Neme/Raletionship (Type, Print) 19b Mailing Address (Street and Number of Rutel Route Number, City of Town, State, Zip Code) (Husband) James Smutek Haight Funeral Home & Chapel P.O.Box 195 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Nema of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removal from Stete permit. Page Department of Important: If any Injury or Crest Lawn Mem. Gardens 12/24/98 Marriottsville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Sykesville, Md. 21784 21. Signeture of Funerel Service Licensee Haight Funeral Home & Chapel P.O.Box 195 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head railure. List only one dause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediata Causa (Final e. Cerebral disease or condition resulting in deeth) hernia Examiner Due to (or es a consequence of): Examiner nening, tis physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in deeth) Lest Due to (or es e consequenca of): certificata be exec Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 88 950 0 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown signed I by 24b. Were autopsy findings available prior to Completed 24e. Was en eutopsy completion of cause of death? page 2 s 1 Ves 32(No 1 □ Yes 2 □ No certificate Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Neturel 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Certifying Phyelolan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Dr. Ciatolla 744176435010001 Dec. 21, 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR, CIATOII+ Street BALTIMORE 1 mD Green 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State DEC 2 3 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Day Month Yaar WALTER WALLACE TRICE 0515 DECEMBER 29, 1998 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) If Undar 1 Year 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) Deys 10 M 20 F Months 218-24-4765 69 July 10, 1929 Maryland Usuel Rasidence of Deceden 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2♥ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7533 Titleist Drive 21801 USA 12. Wes Decedent Ever in U,S.
Armed Forcas?

1☑ Yes 2☐ No
If Yas, Giva
Yeer or Detes: Korea 14. Race - American Indien, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritel Stetus Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 Yas 2√2 No Specify: White 3 ₩idowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Trucking Truck Driver 10 18. Mothar's Nama (First, Middle, Maldan Surname) 17. Fathar's Nama (First, Middle, Last) William Benjamin Trice Bertie Murphy 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) David A. Trice/Son 7533 Titleist Dr., Salisbury, MD 21801 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCramation 3 ☐ Ramovel from Steta 12/30/98 Salisbury, MD 4 Donation 5 Other (Specify) Salisbury Crematory 22. Name end Address of Facility 21. Signeture of Funerel Service Licensee Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximeta Intarval Batwaen Onsat end Death Immediata Causa (Final disaase or condition rasulting in death) 7-10-0AV CEPSIS. Dua to (or as a consequence of): SPAEEN A BSCESS U Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or injury that initiated avants resulting in daath) Lest Due to (or as a consequence of) Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Nhknown 101D 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? TO Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1/Natural 2 Accident

Physician /Medical Examiner

Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

**Funeral** 

Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Massical Examiner must be notified at

Hygiene.

. Pages 1 end 2 should be fill transit of Health end Mental Hitant: Hitem 27 is marked oth

Baltimore,

other

Depertment of important: Meny injury or injury or

the Maryland

physician and s the buriel-trensit Physician/Medical d for use es t signed I A Completed s certificate has b director, page 2 s director, 0 this Certification:

that the death certificate be execu funeral After

Division of Vital Records, P.O. Box 68760, al or Attendeath. To the Hospital or Atter within 24 hours after des To the Funeral Directo completely filled in by the

3 Suicida 4 | Homicide 29a. Certifier

5 Panding invastigation 6 Could not be

Deper

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

1 Yes 2 No

156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 020912 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

30. Nema and ad rass of person who complated ceusa of daath (Itam 23a) (Type, Print) 400 EASTERN SHORE DR. SALISBULLY

odnichi M-D 31. Data filad (Month) 32. Registrar's Signetura

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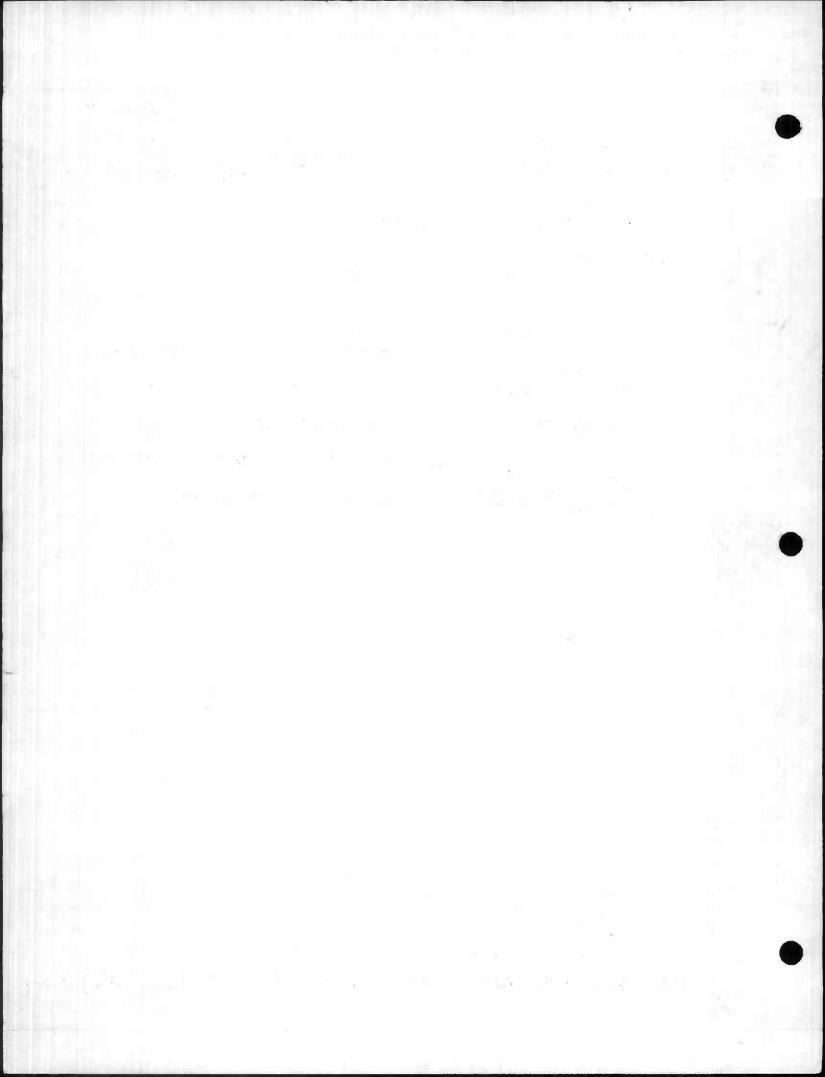
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 45454 Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Deeth 3. Time of Death Yaar **Physician** Month TAYLOR CALVIN R. 1:50 PM DEC. 30 1998 /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WILLARDS WICOMICO 7327 CANAL STREET If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys 1 X M 2 □ F Yrs. Director OCT. 20, 1925 215-20-4470 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND WICOMICO WILLARDS 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21874 USA 7327 CANAL STREET Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Giva Year or Detes: 11 Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, atc.) Race - Amarican Indien, Bieck, White, atc. 1 ☐ Navar Merried 2 X Married 21215-0020 1 ☐ Yas 2 X No Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) COUNTY ROADS FOREMAN 8 i. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 Is marked other th jury or other traumatic event, the Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Maldan Sumeme) Be LEWIS TAYLOR ESSIE JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7327 CANAL STREET, WILLARDS, MARYLAND 21874 MAE F. TAYLOR/WIFE 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 1/3/99 WILLARDS, MARYLAND NEW HOPE CEMETERY 21. Signature of Funeral Service Licensaa 22. Neme end Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximata Interval Betw Onset and Deeth **Physician** Immediate Cause (Final disaesa or condition resulting in deeth) /Medical YRS-COMONARY ARTERY DISEALE Examiner Due to (or es e consequence of): Examiner physician and the bunal-transit Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medicai Due to (or es a consequance of): for use es signed by the at d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1万Yes 2 No 3 Probably 4 Unknown CVA Records. þ 24b. Were autopsy findings available prior to completion of ceusa of death? page 2 should Completed 24e. Wes en eutopsy performed? TLI Yes 22No 1 Yes 2 No certificate Division of Vital al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, ps 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Menner of Deeth 28a. Dete of injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) filled In by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled It 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) Robert B. allen, M.D. 029168 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)
DR Rahert B. Allen, 100 Power St. Salisbury 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State Sereva

Registrar

DEC 3 1 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ached	Physician/	Pert II. Other significant	conditions	contributing to death	but not res	ulting in the und	derlying caus	se given l	In Pert I.	23b, Did t			s cause of death? ly 4 Unknow			
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ate hes	Com									1 <b>X</b> 0 Y	as 2□No	1 🗆 Ye	es 2X No			
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ai Director: /	Certif	3 Suicide 4 Homicide  4 Homicide  4 See. Pleca of Injury - At home, ferm, street, factory, building, etc. (Specify)					et, factory, o	ory, offica 28f. Location (Street and Number or Rural Route Number, City or Town, State)				oute Number,				
uner ely fil	edical	29e. Certifier (Check only one)	Certifying Pi Madical Exa	nysician: To the bes miner: On the basis end menner	of examine	wledge, deeth of tion end/or inve	occurred et t estigetion, in	the time, my opini	dete end pleca, on, deeth occur	end due to the or red et the time, o	ause(s) and <i>me</i> late and pieca,	enner es stete and due to the	d. e cause(s)			
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To the Funeral (		1/1/2	R. Je	reen	4	10	D	)-446			12/	30/9	8			
To the complet		29b. Signature and title 3 30. Name and address of EFFREY G	f person who				rint)	NATI	34 IONAL NA	VAL MED 20889-	/2/ ICAL CE	30 /9 NTER	8			

DHMH 16 Rev 6/95

AKH , NA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month Year 205 PM Rose Reiswig Gerringer December 28, 1998 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Lutherville 11111 Green Spring Avenue 8. Date of Birth (Month, Day, Ye Jan. 18, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1906 Colorado Hours Months Davs 1 M 2 F 92 Yrs 353-15-3112 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ₩ No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11111 Green Spring Avenue 21093 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, atc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Kammerzell George Reiswig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21093 19a. Informent's Name/Relationship (Type, Print) 11111 Green Spring Avenue, Lutherville, Maryland Rose Alice Gerringer/daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stete 4 Diponation 5 Other (Specify) 21. Signat and Funer I Service Licensee S Wade, Director 25 Marted Atlant Ship Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. P. 11. Enter the disease, or compactifies that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseasa or condition resulting in death) ASCUD Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 207No Other: 4 Nursing Homa Seesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Netural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Examiner physician end the buriel-transit The law requires that the death certificate be assecuted Box 68760 P.O. Records, page 2 s Division of VItal or Attending Physicien: this After deeth. To the Hospital or Attendit within 24 hours effer deeth. To the Funeral Director: At completely filled in by the fu

Examiner Physician/Medical þ Completed 80 Certification: To edical

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

"natural", or frama 23a or adical Examinar must be

pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: if item 27 Ia marked other than "natural", or fran eny Injury or other treumatic avent, the Heddel Esterning

Physician /Medical

Baitlmore, Maryland 21215-0020

the Menyland x 28a-f show

WITH

death

State Registrar

DHMH 16 Rev 6/95

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 1 4 1999

COUINCAN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

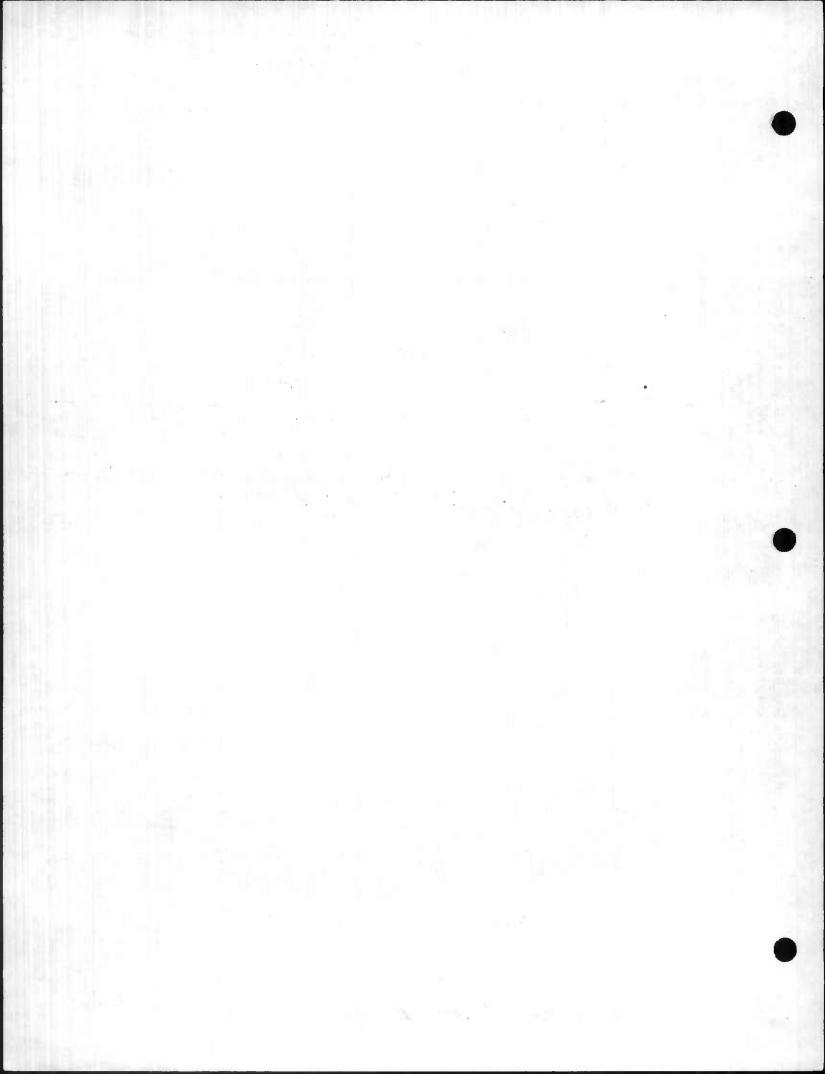
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-12990

YOUL KO TOWSON MD 21204



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3 Time of Death **Physician** El, Minnick 1810 1998 Dec 28 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3801 Bell Road Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 € M 2 □ F Yrs. 212-34-3384 Director Feb. 12, 1937 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1 Yes 2 No Director Montgomery Burtonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 3801 Bell Road 20866 USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Stetus filed within 72 hours after Hygiene. Other then "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Giva Yaer or Detes: 1 Nevar Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 8 Sheet Metal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked or Mamie E. Hume Lucian D. Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Bell Road, Burtonsville, MD 20866 Ruth Bayne/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or page. 12/31/98 Mine Run, Virginia New Hope Bapt. Ch. Cem. 21. Signature of Funeral Service Licensee 22. Nama end Addrass of Fecility Fleck Funeral Home, Inc. reger 7601 Sandy Spring Road, Laurel, MD 20707 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications first caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) nanahon Examiner Due to (or as a consequence of): Examine Umonia physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. certificata be Physician/Medicai Dua to (or as a consequence of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yas 2 No Division of Vital 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t the Hospital or Attanding 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as a second.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier y ma Dome D00428 metical park pr 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 2101 BRECHER

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 4 1999

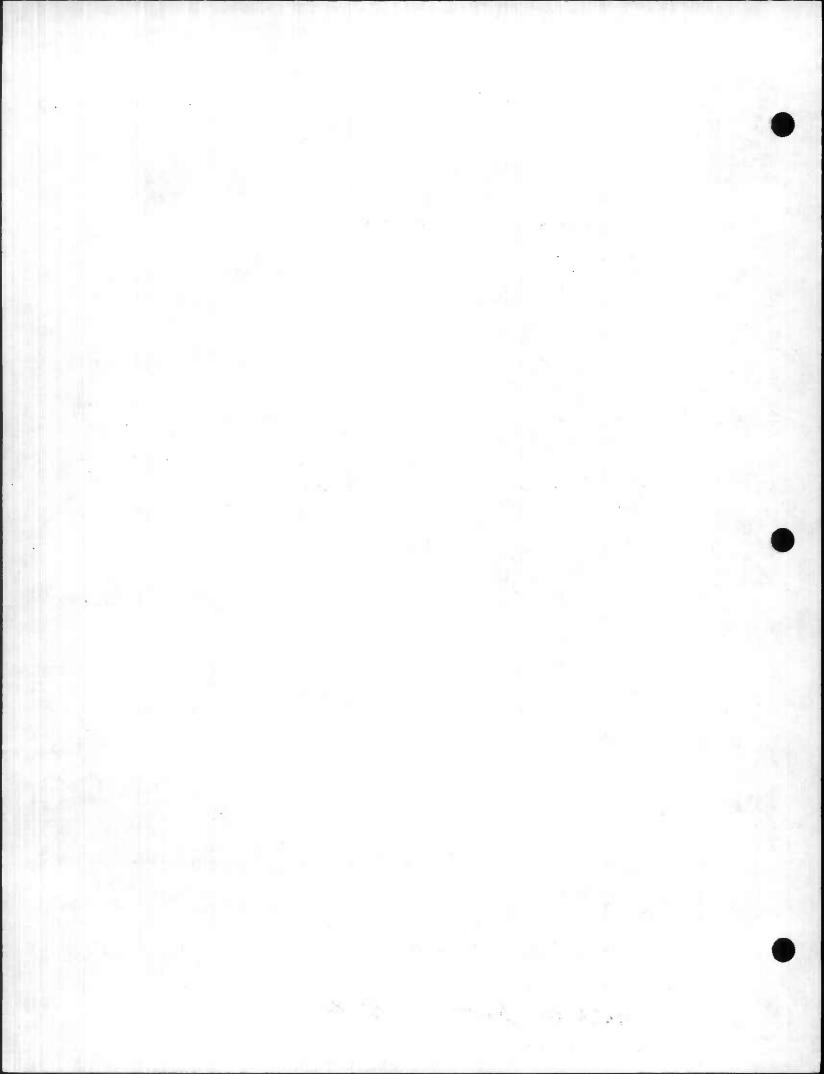
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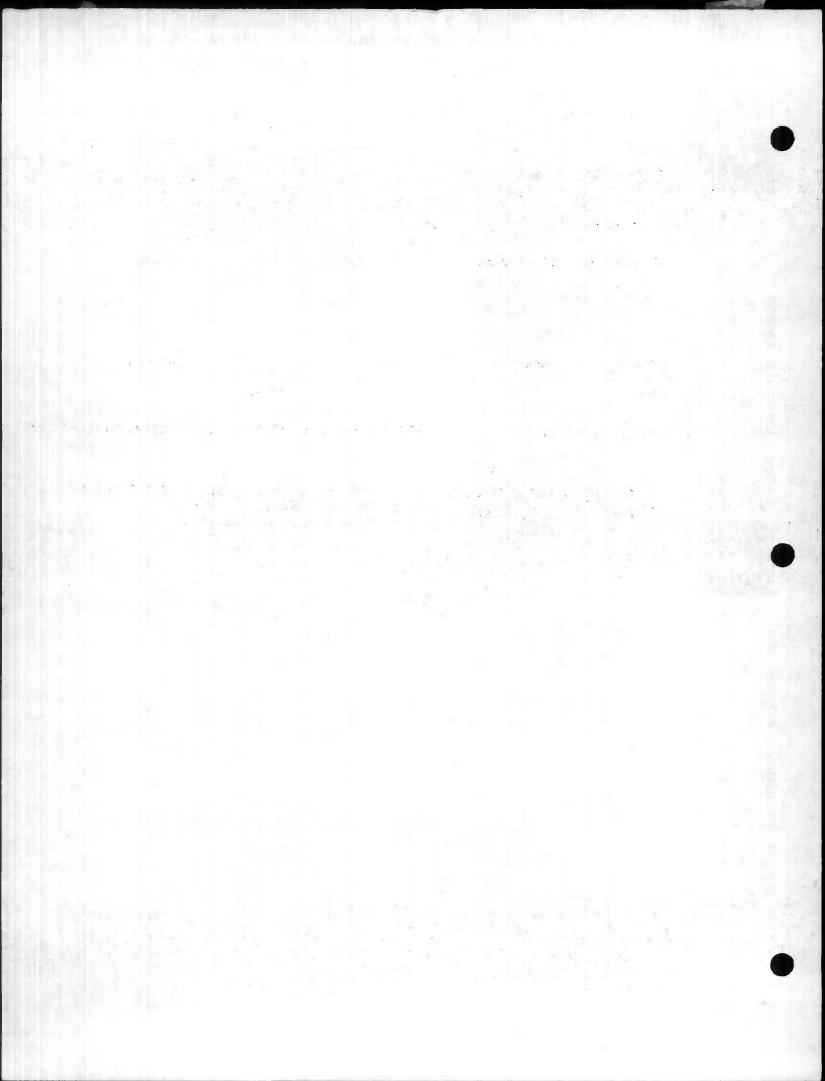
32 Registrar's Signeture



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	1. Decedent's Nama (First, Middla, Last	()		1:	2. Date of Death		3. T	ima of Death	
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miner	4a Facility Nema (If not institution, giva  MARYLAND	GENERAL	- MOSPITAL	4b. City, Town, or Local BALTIM		4c. County of Baltin	of Death nore Cit	ty	
ral tor		7. Aga (In yrs M 2□ F 57	: last birthday) If Under 1 Yea Months Deys	r If Under 24 Hrs. s Hours Min.	B. Date of Birth (Month, Day, July 28	Year) , 1941	9. Birthplaca (S Country) unknown	Stata or Foreign	
	Usuai Rasidenca of Decedant  10e. Stete 10b. County	10c, C	ity, Town or Location				10d. Ins	side City Limits	
by Funeral Director	Maryland Baltimon		altimore					Yas 2□ No	
2	10e. Street and Number		10f. Zip Coda		10	g. Citizen of W	/hat Country?		
O	·501 West Frankli	n Street	21201			U.S.A.			
by Funeral Director	11. Marital Status  1 X Navar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Evar in I Armed Forces? Un 1 Yes 2 No If Yas, Giva Yaar or Datas:	J.S. 13. Was Dacedant of Known If Yas, specify Cu		ify Yas or No- ican, atc.)	Biacl	- Amarican Ind k, Whita, atc. Black	ian,	
Be Completed	15. Decedant's Edi (Specify only highast grad	ucation	16a. Decedant's Usuai Occi (Giva kind of work don lifa. DO NOT use retir	upation	7	16b. Kind of Bu	sinass/industry		
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	19a. Informant's Name/Relationship (T		19b. Mailing Addrass (Street 12900 Tobacc						
	Philip Govan/cous		Place of Disposition (Name of				City or Town, Si		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify,	Removal from State	cemetery, crematory or other p	lace)					
once.  To Be Completed by Funel	21. Signature of Fu arai Sarvice Licens ROTald S. Wa			ress of Facility Board		. Balti	more St	reet	
1	23a. Part 1. Entar tha disease, or comp hock, or heart feilure. List only of	plications that causad the das one cause on each line.		e, Maryland ying, such as cardiac or		ast,	Appro- Inten- Onse	oximata val Between et and Deeth	
	Immediate Causa (Final diseasa or condition TSRONCHOPNEUMONIA							DAYS	
	diseasa or condition rasulting in death)	a	(or as a consequence of):	DIVIDIVIA			יוע	7	
ner		Dua 10	SEPSIS				his	EKS	
ami	Sequentially list conditions.	b. Dua to	(or as a consequenca of):					3	
EX	Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Ceusa (Disaesa or Injury	F	NDOCARDIT	15			WE	EEKS	
edical Examiner	thet initieted events rasulting in death) Last		(or as a consequence of):						
by Physician/M		d							
hysic	Part II. Other significant conditions co			givan in Part I.	23b. Did to		atribute to the c		
y P		SEVERE	ANEMIA						
Completed b					24e. Wes e perform	n eutopsy ned?	available	ion of cause	
E O					10 Y	2 200	1 ☐ Yes	2 No	
BeC	25. Was case referred to medical			26. Place of Death	(Check only on	ө)			
To	examiner? 1 ☐ Yes 2 🗙 No	Hospital: Unpatient 2[	□ ER/Outpatient 3□ DOA   C	Other: 4 Nursing Hom	a 5 🗆 Rasida	inca 6 Oth	ar (Specify)		
edical Certification:	27. Mannar of Death  10 Naturai 5 Pending 2 Accident Invastigation		28b. Time of Injury M 1	jury at 2 fork? Yes 2 No	8d. Dascribe ho	ow injury occurr	red		
ertific	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida determined	28a. Placa of Injury - At building, atc. (Spec	homa, farm, straat, factory, officially)	9 2	8f. Location (St City or Town	reet and Numb o, Stata)	er or Rurel Rou	te Number,	
dical C	29a. Certifier (Check only one)	ysician: To the best of my kr iner: On the basis of examinand menner stated.	nowledge, death occurred et tha nation and/or invastigation, in my	time, deta end placa, a opinion, daath occurre	nd dua to the co d et the tima, d	ouse(s) and ma ata and placa,	nner as stated. and dua to the c	causa(s)	
	29b. Signetura end title of certifiar	and mornior stated.	29c. Lica	nse number	2	9d. Data signe	d (Month, Day,	Year)	
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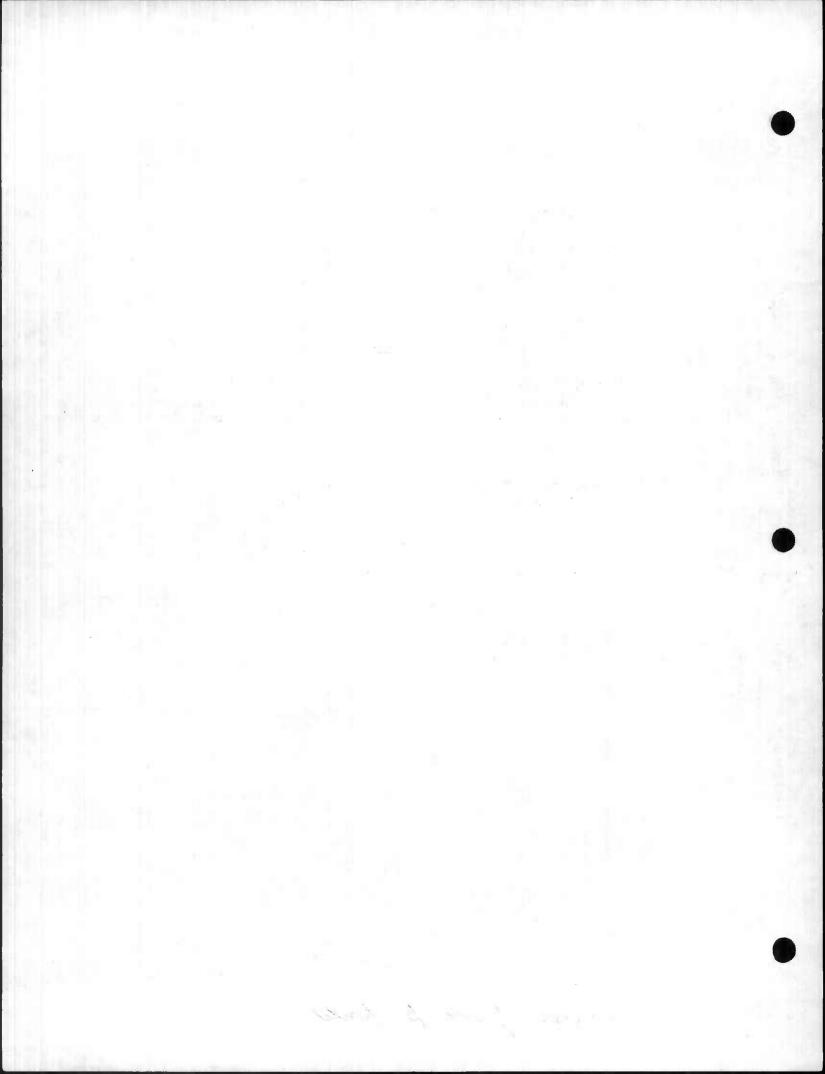
State Registrar



State of Maryland	d / Department of Hea	Ith and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dey Year December 20, 1998 **Physician** 10:00 AM Ruth Osgerby Strong /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | Sandy Spiling
| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 23, 1914 Friends Nursing Home Montgomery 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2√F 311-42-4686 84 Yrs. Director Usual Residence of Decedent Worle 10a, Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at Maryland Montgomery Sandy Spring Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1015 Quaker Knoll Road 20860 U.S.A. Funeral deeth 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Eseminants. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Carrie Neilson Earl William Osgerby 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Quaker Knoll Road, Sandy Spring, Maryland 20860 Laurence E. Strong/husband 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee Ronald, S Director State Anatomy Board, 655 W. Baltimore Street Wade, 1 Baltimore, Maryland 21201 23a. P. rt1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** OLIVO YONTINE DECIENERATION MONTHS /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner ettending physician and for use as the burlei-transit or Attending Physician: The law requires that the death certificets be associed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): signed by the e P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Discussing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mining of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) n 24 hours after ne Funeral Direction niately filled in b 4 Homicide Hospital 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune complately fi (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) My Completed cause of death (Item 23a) (Type, Print) 30. Nama and addr iss of person PHUP DX #328, OLAEY MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible,

ate	of	Maryland /	Department	of	Health	and	Mental	Hygiene	
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Physician	
/Medical	_
Examiner	4

**Director** with the Meryland r 28a-f ahow Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours effer death w Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Example mails page.

3altimore, Maryland 21215-0020

**Physician** /Medical Examiner the death certificeta be axecuted

physician end the burial-transit 88 980 0 signed by the e certificata has b this funeral death.

Division of Vital Records, P.O. Box 68760,

Attanding

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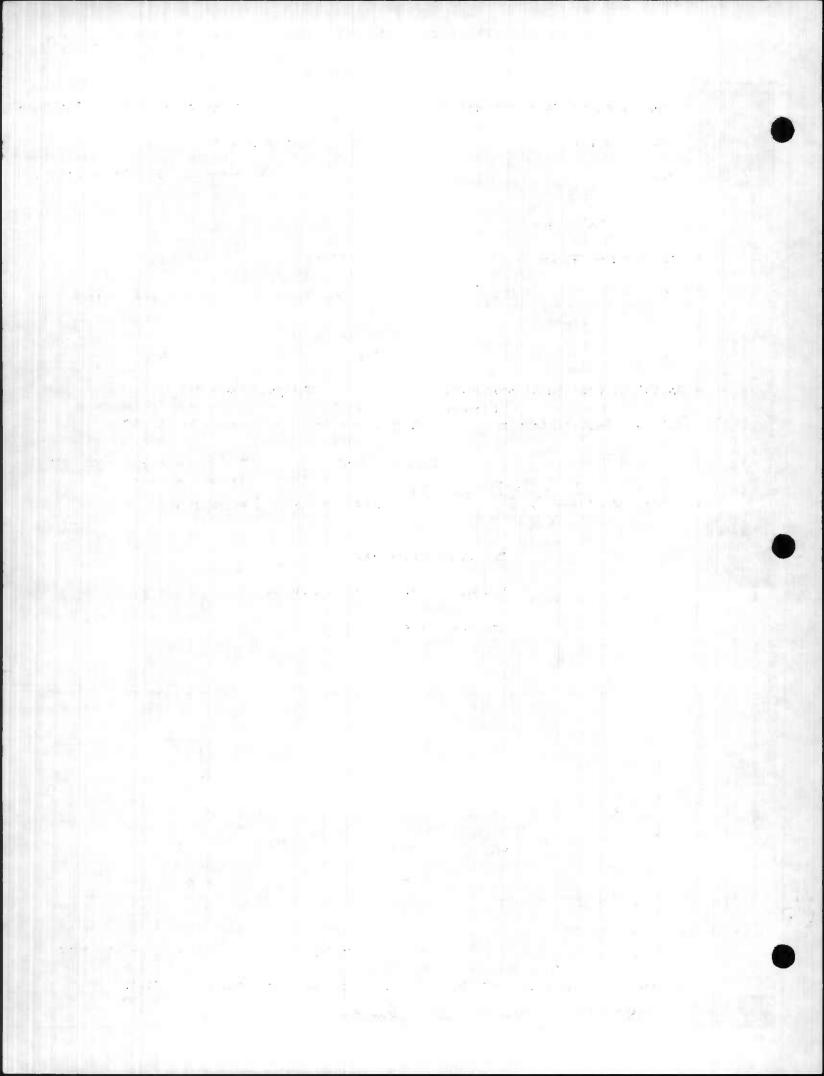
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To the Hosp within 24 ho To the Fund completaly it

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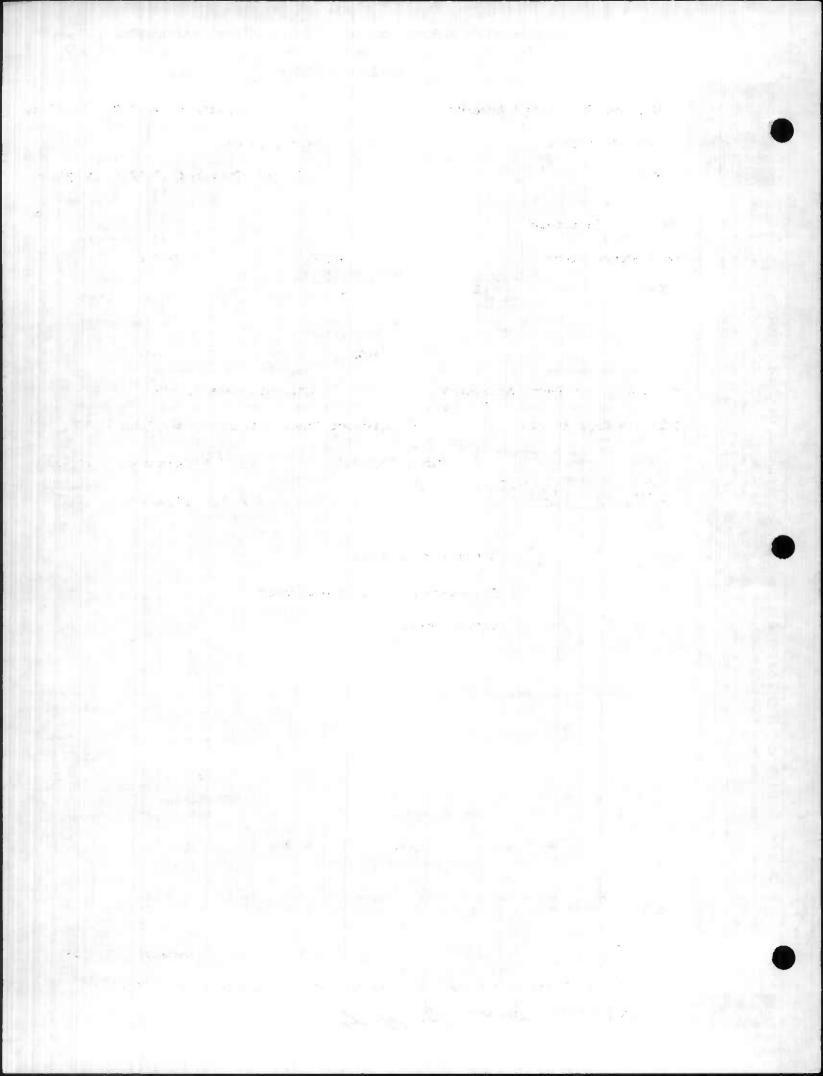
Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Baby Girl "B" Buchi Ahiabuike December 12,1998 10:20 am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Sinai Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□ M 2X F Yrs. December 12, 1998 None 17 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 42 Wyndmoor Place 21207 Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yeer or Detes: 14. Reca - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1X Never Merried 2 Married 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Chinyere Hope Ezirim Smithison Omye Buchi'Ahiabuike 19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 42 Wyndmoor Place Baltimore, MD 21207 Chinyere Buchi'Ahiabuike 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Baltimore, MD Sinai Hospital 21. Signature of Funeral Service Licansee 22. Neme and Address of Facility Beley tacilities 23 Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. BELVED SUEAUE Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Extreme Prematurity Due to (or as e consequence of): Examiner Premature Rupture of Membranes Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Chorioamnitis Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 1 ☐ Yas 2 No 2 No 25. Was cese referred to medical examiner? Be 26. Placa of Death (Check only one) To Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident N/A N/A N/A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide N/A 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) December 12, 1998 D0051180 30. Name and address of person, the completed ceuse of death (Item 23a) (Type, Print) Gloria Bowles-Johnson, MD 2401 W. Belvedere Ave. Baltimore, MD 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State JAN 1 5 1999 Registrar



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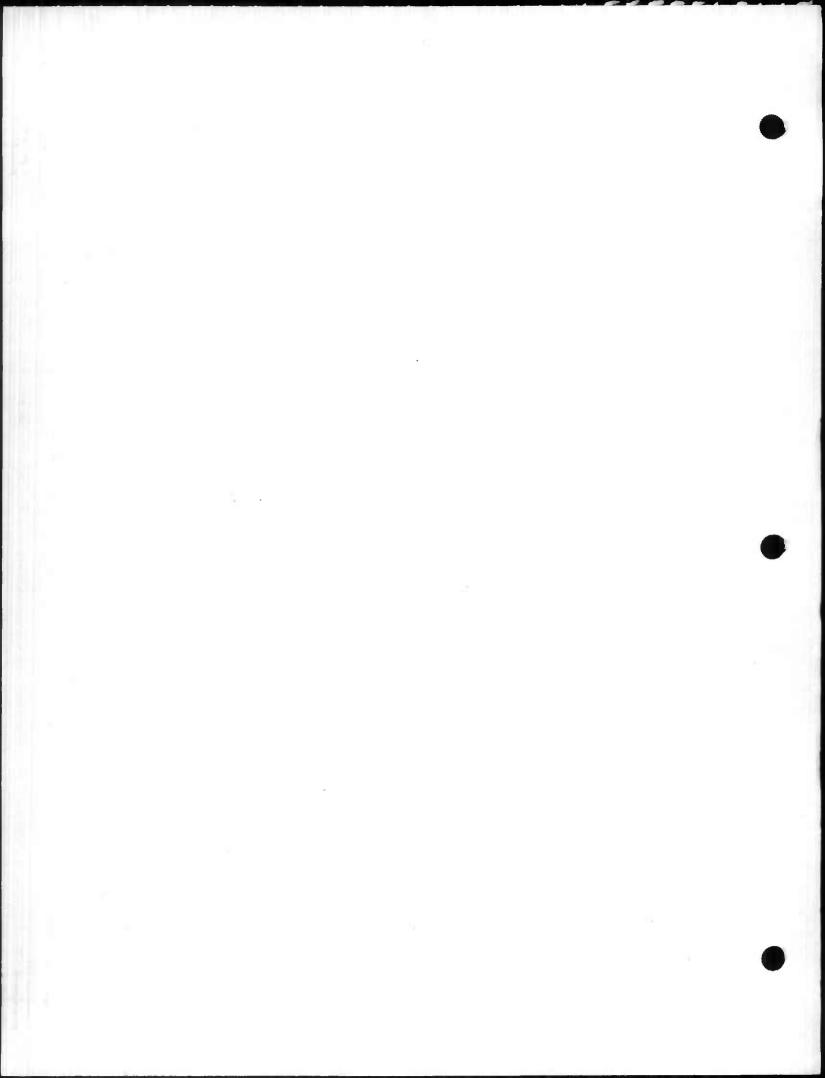


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Myglene prior to burial, cremation, or removal.	
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury or other traumatic event, the medical examiner must be notified at once	

	FOR STATE REGISTRAR	STATE OF MARYLAND	) / DEPARTMENT () CERTIFICATE (	F HEALTH AND I	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last, DELIMARIO SHH				2. DATE OF DEATH MONTH DAY	98	3. TIME OF DEATH 2:36 A.M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (in yrs	YRS. Is UNDER 1 YE	AR IF UNDER 24 HRS. YE HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year)	8. BIRTHI Country	PLACE (State or Foreign
TOR	90. FACILITY NAME (If not inetitution, give  PLINCE GEOLGE  RESIDENCE OF DECEDENT	street end number) FS HOSPITAL CE		WN OR LOCATION OF DE		COUNTY OF DE	ATH GEORGES
DIRECTOR	10a, STATE 10b, COUN	KE GEOLGES	10c. CITY, TOWN OR L				10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	502 - 62NO	PLACE, APT.	C	10f. ZIP CODE 2074		U.S.	HAT COUNTRY?
BY	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 1F YES, GIVE WAR OR DATES		DECENDENT OF HISPAN I, specify Cuban, Mexican YES 2 NO Specify		0— 14. RACE Black, Specifi	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION 16a completed) College (1-4 or 5+)	DECEDENT'S USUAL OCCU (Give kind of work done durin life. Do NOT use retired.)	g most of working	166. KIND OF BUSINES		
BE COM		MARIO HI		16. MOTHER'S NAI	AE (First, Middle, Maiden Surna LATRESE	me)	KE
5	19a. INFORMANT'S NAME (Type/Print) PLANCE GEORGES	HOSP. CTR.	3001 HOSPI	oot and Number or Rural R	oute Number, City or Town, State		20785
	20a. METHOD OF DISPOSITION  1	cometery.	CEAND DATE OF DISPOSITIO	N (Name of	Will CHE	City or Tow	R My
	· Atll	UUG 1-11	199 PC	MC CH	BENY /	ht)	20785
	23. PART / Enter the diseases, or ahook, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. DUE TO (OR AS A CON	unils	mode of dying, auch	as cardiac or reapirator	y arrest,	Approximata Interval Batween Onset and Death
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CON		Pervix			
A A	PART II. Other aignificant condition	na contributing to death but n	ot resulting in the under	iying ceuse given in i	Part i. 24e. WAS AN AUTO PERFORMED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
: MEDIC	DID TOPACCO LISE COM	TRIBLITE TO CALISE OF D	ratu vec 🗆 No		1 TYES 2 X N	°	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 ND		LACE OF DEATH (Check only OTHER:				
ву РНУ	27. MANNUR OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c	INJURY AT WORK?	28d. DESCRIBE HOW INJURN	Y OCCURED	
ETED E	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	t home, farm, street, factory,	office	28f. LOCATION (Street and Nu City or Town, State)	imber or Rural Ro	ute Number,
COMPLE		SICIAN: To the best of my knowledge IER: On the basis of examination and					end manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	Mada	MD	29c. LICENSE NUM	29d.	DATE SIGNED	Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WI	MARIE-	HRIST 1	NE			
	JAN 1 5 1999	32 REGISTRAR'S SIGNATUR	9. Popul	A			



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 15 2:17A.M Baby Boy Nickles /Medical Roseda ( ) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 15, 1 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore enter ospital guare 6. Sex ranklin-5. Social Security Number Birthplace (State or Foraign Country) 7. Aga **Funeral** NOM 2DF Days none 1998 Baltimore Director Usual Residence of Deceden the Maryland 10d. Inside City Limits r 28a-f show 10a State 10h County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Baltimore County Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or Items 23s or edical Examiner must be a U.S.A. 21237 8114 Analee Avenue Funeral death 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/industry 15. Decedent'a Education (Specify only highast grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Hygiene. 0 none 0 none marked other 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental unknown Denise Nickles 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8114 Analee Avenue, Baltimore, Maryland 21237 Denise Nickles/mother 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Specify) in state 21. Signature Romald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 e 1. Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, tock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed siclan and a bunal-trans Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Physician/Medical physic that Due to (or es a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy lindings available prior to completion of causa of death? been sig 24a. Was an autopsy Completed ils certificate ha 2 □ No 1 Yas 2□ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case rafarrad to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Deatl 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending Invastigation 1 ☐ Yes rector: A 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa ol Injury - At home, farm, street, lactory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcomplataly filled in b 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medicat Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartilier 29c. License number

State Registrar

Division of Vital Records, P.O. Box 68760.

Kles, Babyboy

31. Data filed (Month, Day, Year)

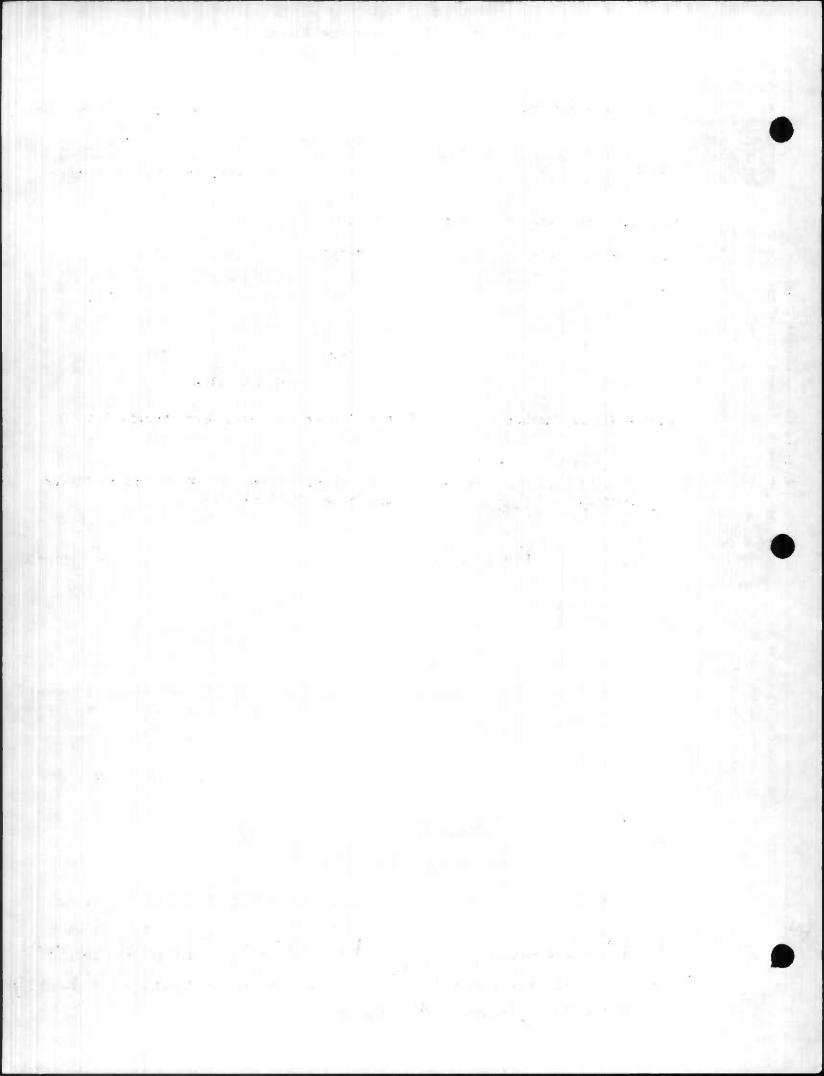
JAN 1 5 1999

9000 Fra Patricia Kichardson 32. Registrar'a Signature

30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print)

nKinSquare Drive Baltimore, MD21235

**DHMH 16 Rev 6/95** 

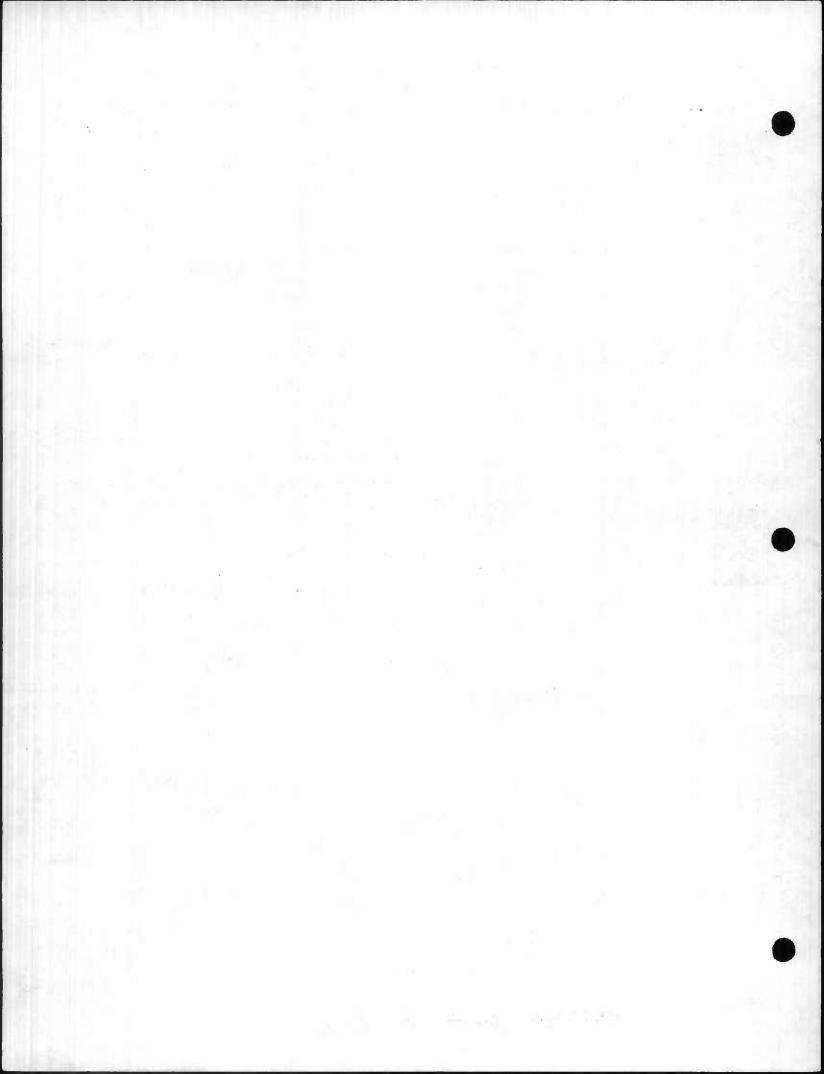


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene PER F.H G767 Certificate of Death ITEMS: #11, 15,16A-B, 20A-C, 21,22 PER F.H G767 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** E. RUSSEI rau December 20, 1998 9:50 PM /Medicar 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1722 West Pratt Street Baltimore Baltimore City If Under 24 Hrs. 8. Date of Birth (Month, Day, Year), Oct. 16, 1926 Oh10 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 315-38-3859 1₩ M 2□ F 72 Director Usuel Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at Maryland Baltimore City Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1722 West Pratt Street 21223 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Meritel Stetus unknown Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within I nent of Health and Mental Hygiene. int: If Item 27 is marked other than "I Elementery/Secondary (0-12) College (1-4or 5+) VARIOUS TRADES unknown LABORER unknown-NA -unknown Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if Nem 27 is any injury or other trau page. Sheila Patterson/niece 1722 West Pratt Street, Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 DKBurial 2 Cremation 3 Removal from State 4 Donation 5xDother (Specify) in state GARRISON FOREST VA CEMETERY 1-15-99 OWINGS MILLS, MD 22 Name and Address of Facility WM., C. MARCH FUNERAL HOME STATE AND PROPERTY HOME BALLIMOTE, Maryland 21201 21202 21. Signature of Funeral Service Licensee Robard Son Wade, Director ✓ DONALD GAITHER 23e. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart feilure. List only one cause on each line. **Approximate** Interval Between Onset and Death Physician fmmediete Cause (Final diseasa or condition resulting in death) /Medical Examine anteny disease Examine GONO NUM physician and the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) 68760 NiaMI o cardin Physician/Medicai Due to (ones a consequ Box 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? cate has been significant category. 24a. Wes an autopsy performed? Completed 1 ☐ Yes No 1 Yes 28 No Division of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Dete of Injury (Month, Day Year) 27, Menner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After Attanding 1 Netural 5 Pending n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fun 1 Yes 2 No investigetion 2 Accident 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide ò To the Hospital of within 24 hours at To the Funeral Dicompletely filled in Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

[In Medical Examilier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29e. Certifier er: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person o completed cause of deeth (Item 23a) (Type, Print) AN Tiled (Month, Day, Year) 32. Registrar'a Signeture State JAN 15 Registrar

**DHMH 16 Ray 6/95** 



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

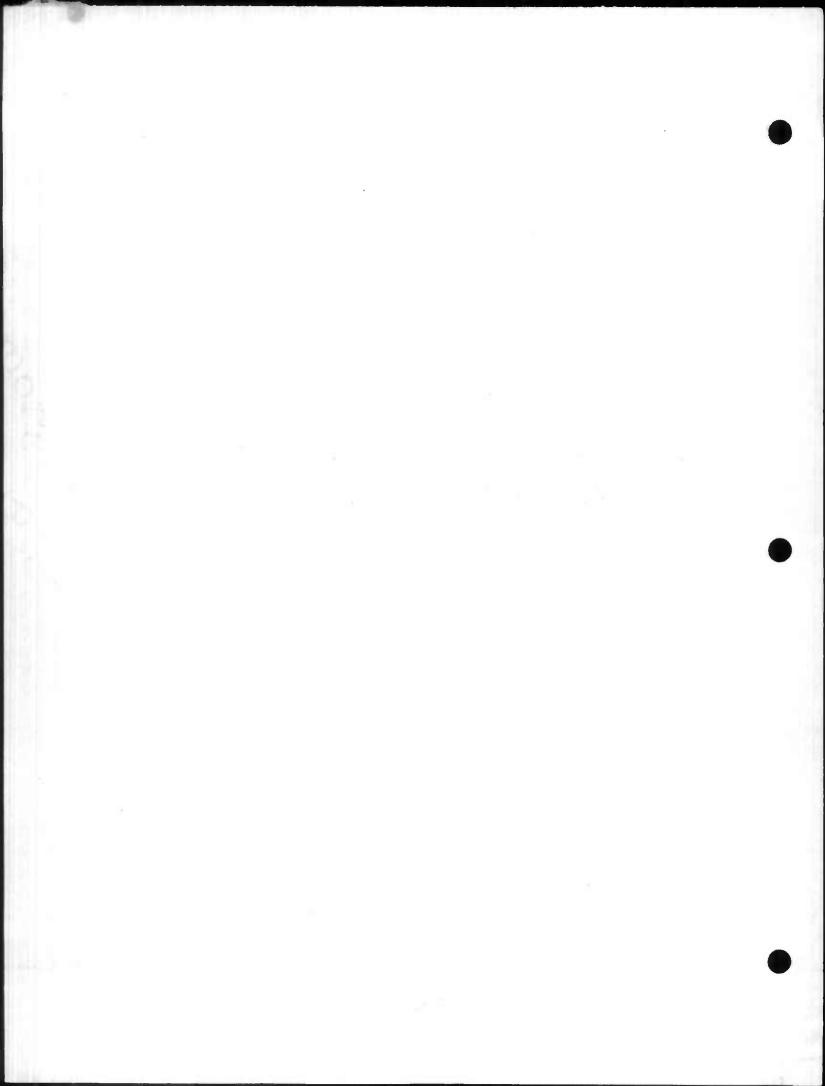
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1	-	FOR STATE REGISTR	Al
Γ	1. D	ECEDENT'S	N

#### STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

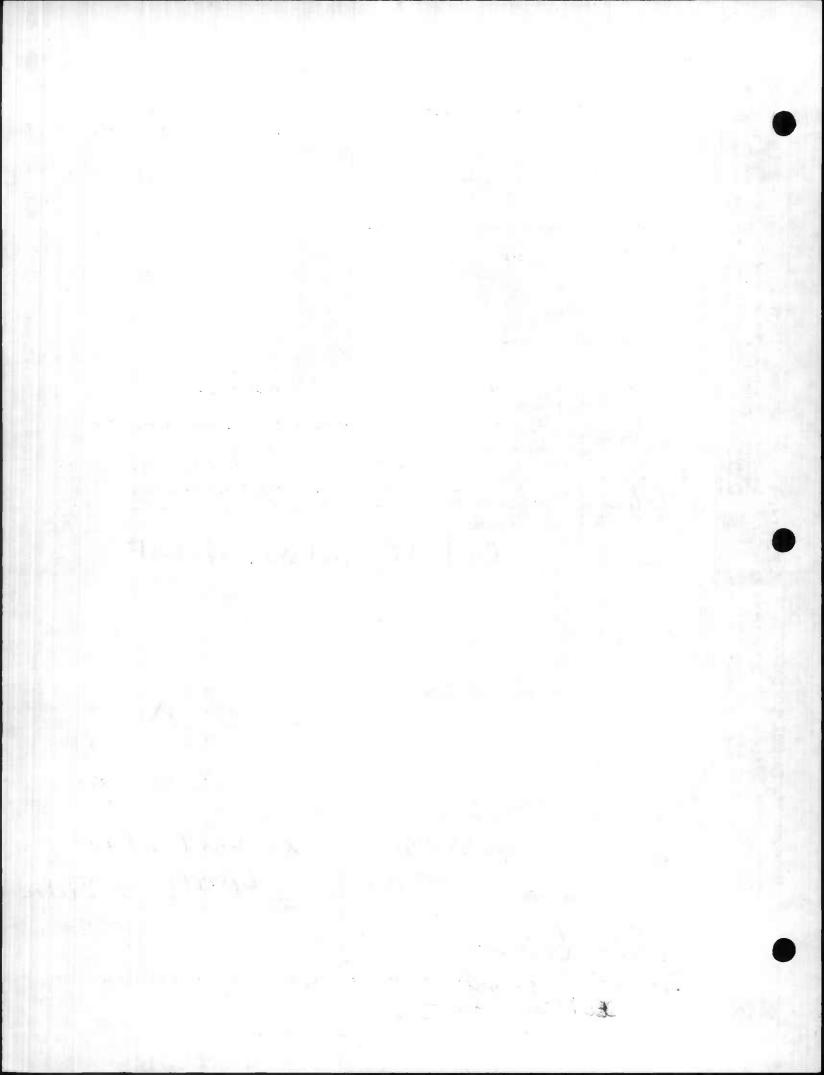
	1 - REGISTRAR CERTIFICATE OF DEATH	REG. NO.	
	Babyboy Jeffrey Via	DATE OF DEATH MONTH DAY 12-09	98 0718 A M
	NONE 1 M 2 F YRS. MONTHS DAYS HOURS MIN.	DATE OF BIRTH (Month, Pey, Year)	8. BIRTHPLACE (State or Foreign Country) Mary (and
TOR	90. FACILITY NAME (If not institution, give street and number)  PRINCE GEORGES HOSPITAL CENTER CHEVERLY  RESIDENCE OF DECEDENT	-000	NUNTY OF DEATH
DIRECTOR	100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION PLINCE GEORGES LANDOUER		10d. INSIDE CITY LIMITS? 1  FS 2 NO
FUNERAL	10. STREET AND NUMBER  101. ZIP CODE  20785	"	ITIZEN OF WHAT COUNTRY?
В	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, apecify Cuben, Maxican, Property of the pr	ORIGIN? (Specify Yes or No— uerio Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify:
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  College (1-4 or 5 +)  College (1-4 or 5 +)	16b. KIND OF BUSINESS/III	
BE CON	LAMONT RENE WILLIS JACQUA	(First, Middle, Malden Surname)	9
10	190. INFORMANT'S NAME (Type/Print) PRINCE GEORGES HOSPITAL CTR. 3001 HOSPITAL DRIV		
	20a. METHOD OF DISPOSITION  1 Burlei 2 Cremation 3 Removal from State  4 Donation 6 Other Company Comp	19/9 KHBV	BREW MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSES  22. NAME AND ADDRESS OF FACILITY  PGIC CHE	Week 1	1020785
	23. PANT I. Enter the diseases, or complications that caused (the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  BUE TO (OR AS A CONSEQUENCE OF):		Approximate interval Batween Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. Extent prenativity  DUE TO (OR AS A CONSEQUENCE OF):  c.  DUE TO (OR AS A CONSEQUENCE OF):  d.		
EDICAL	PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Par	24s. WAS AN AUTOPS PERFORMED?  1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  TO
AN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  28. PLACE OF DEATH (Check only one)  EXAMINER?  1 YES 2 WO OTHER:  1 YES 2 WO A 4 Nursing Home 5 Residence 6	Other (Specify)	
ву РНУ		d. DESCRIBE HOW INJURY O	CCURED
ED		tt. LOCATION (Street and Numb City or Town, State)	per or Rural Route Number,
COMPLET	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to to medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.		
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER  Lama L. M. Neonatulojit 296. LICENSE NUMBER  290. NAME AND ADDRESS OF DESCRIPTION OF DEATH WITH AD US. OF DEATH WITH ADDRESS OF DESCRIPTION OF DEATH WITH ADDRESS OF DESCRIPTION OF DEATH WITH ADDRESS OF D	737 >	ATE SIGNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PYRSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  LAURA L. JENNINGS, MD, PEOS DEPT., 3001 HOSPITAL DR	IVE, CHEVE	Ruy 110 20785
	31. DATE FILED (Noon), 50, Your) 5. 1999		



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 4 1466

State of Maryland	/ Department of F	Health and Mental	Hygiene

CLYDE D. A	SBROY		Certific	ate of	Death	R	eg. No.	, , , , , ,	
Dhyaisian	Decedent's Name (First, Middle, Last)				2. Date of Death 3. Tima of De				
Physician /Medical Examiner	Clyde Douglas Asbury  4a Facility Name (If not institution, give street and number)			4	Month DEC.  4b. City, Town, or Location of De		22, 1998 4c. County of	0920 AM	
Examiner	24344 FLAMINGO				GAITHER	SBURG	MONTGO		
Funeral Director	212-54-4880 49 Vis. October 17, 1949 Maryla						Birthplace (State or Foreig Country)  Maryland		
pu .	Usual Residence of Decedent  10a. Stata 10b. County	10c. C	City, Town or Location					10d. Inside City Limits	
Mery to	Maryland Mantas							1 ☐ Yes 2√ No	
4 1.4.1.3-00.2.0.d with the Meryland within 72 hours effer death with the Meryland plene. Then "natural", or hems 23s or 28ed show the Medical Exeminar must be notified as completed by Funeral Director.	Maryland Montgomery Gaithersburg  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								
	24344 Flamingo Terrace 20882						U.S.A.		
	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		ecedent of H specify Cubs		Specify Yes or No- to Rican, etc.)	14. Rece -	American Indian, White, etc.	
2 ho	15. Decedent's Ed		16a. Decedent's U	Isual Occup	ation	adata a	16b. Kind of Busin	ess/Industry	
led within 72 ho lyglene. ner than "neturn ft, in "red Completed	(Specify only highest gra-	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)				rking			
254	8		Lands	caper			Landsca	aping	
E 28 6	17. Father's Name (First, Middle, Last)				18. Mother's Ne	Neme (First, Middle, Meiden Surneme)			
should bud Mente	Clyde Harrison				-		land Rogers		
12 sh 1 s m	19a. Informant's Name/Relationship (7						Il Route Number, City or Town, State, Zip Code) 20882		
permit. Pages 1 and 2 should Department of teath and Man Important: if Item 27 is marks any Injury or other traumatic ance.	Elizabeth R. Asbu		24344 F	laming	go Terra			Maryland	
	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cremetory	or other plea		2.5	20c. Location - Cit		
taner tanti	4 Donation 5 Other (Specify	) Pa	rklawn Mer	norial	Park	12/28/98	Rockvil	le, Maryland	
Depertr Depertr Imports eny Inji	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility								
	23a. Part. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List onlyfone cause on each line.  20872  Approximate Interval Between Onset and Deeth Onset and Deeth Onset and Deeth								
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Con	out Ca (or as a consequence	rs/5		ydof (		Onset and Deeth	
ing physician and e.e. the burlet-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
eth ce for us		d							
requires that the been signed by it should be detech	Part II. Other significant conditions contributing to death but not resulting in the under						Old tobacco use contribute to the cause of death Yea 3 Probably 4 Unknow		
						24a. Was a perfori		24b. Were autopsy findings available prior to completion of cause of death?	
						Dors	es 2 No .	VoYes 2□ No	
entificat ector, p	25. Was case referred to medical				26 Place of De	ath (Check only on		7.00 20.00	
Attending Physicien: in death. ector: After this certific by the funeral director, iffication: To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Oth	or	Home 5(3) Reside		(Snecity)	
Physical Phy	27. Manner of Death	28a. Date of Injury	28b. Tima of	3b. Time of Injury at Work?    Substitute			be how injury occurred  Language State of Self  on (Street and Number or Rural Route Number, Town, Stete)  Your State  The Number of Reference		
offine fun	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	1841 M						
xeec ti	Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	city)						
hour hour hour ly fills		reician: To the best of my kr							
To the Hospital of Within 24 hours a To the Funces I completely filled	one)	iner: On the basis of examir and manner stated.	acon anwor investiga						
withi To th	29b. Signature and title of certifier / Club ( Torke AW)			29c. License number O.C.M.E			29d. Date signed (Month, Day, Year) DEC . 23, 1998		
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Tick with the completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201								
State	31. Data filed (Months Ory Year) 8	1998 32. Registar's Sign	course 4	do	alla/			1 3	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 4 461 State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Vest BARBARA ARTHINE DECEMBER 23, 1998 BAKER 6:00 A.M. 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 1 M 2 F Months Deys Hours Min Yrs. June 28, 224-72-3947 68 1930 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a Stete 10c. City, Town or Location Maryland Frederick Thurmont YYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 1 Sandy Spring Court 21788 U.S. of A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2\2\No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes XXNo Specify: Specify: Caucasian 3 DWidowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Mabel Taylor Green Carl Lake 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Rebekah J. Stansberry - Daughter 56 W. Frederick St., Walkersville, Md. 21793 20b. Pleca of Disposition (Neme of cemetery, cremetery or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Metropolitan Crematory 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 12-24-98 Alexandria, Virginia 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility
Brown Funeral Home 21. Signature of F eral Se ice Dicensee Lovettsville, Virginia Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart failure. Hist only one cause on each line. Approximete Intervel Between ARDOMOPE Immediete Cause (Finel diseese or condition resulting in deeth) Due to (or es e consequenca of) Due to (or es e consequence of). 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed' 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred

Physician /Medical **Examiner** 

physician and s the burial-tran

60 attending for use as

signed by the a

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has ye 2 page

After this certificate funeral director, pag

Director: /

or Attending Physician:

death.

after

To the Hospital of within 24 hours at To the Funeral D completely filled in

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

Be

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Certification:

edical

**Physician** 

/Medical

Examiner

Funeral Director

à

Completed

**Funeral** 

**Director** 

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural", or frame 23a or 28a-f ahow any injury or other traumatic event, the Medical Exactive matter by notified anone.

altimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical 1 Yes 2 No 27, Menner of Deeth Neturel

5 Pending investigation 2 Accident 3 Sulcide 6 Could not be 4 Homicide

28e. Dete of Injury (Month, Dey Year)

28c. Injury at Work?

1 Yes 2 No 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State) CCartifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture and title of pertifier

29a Certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

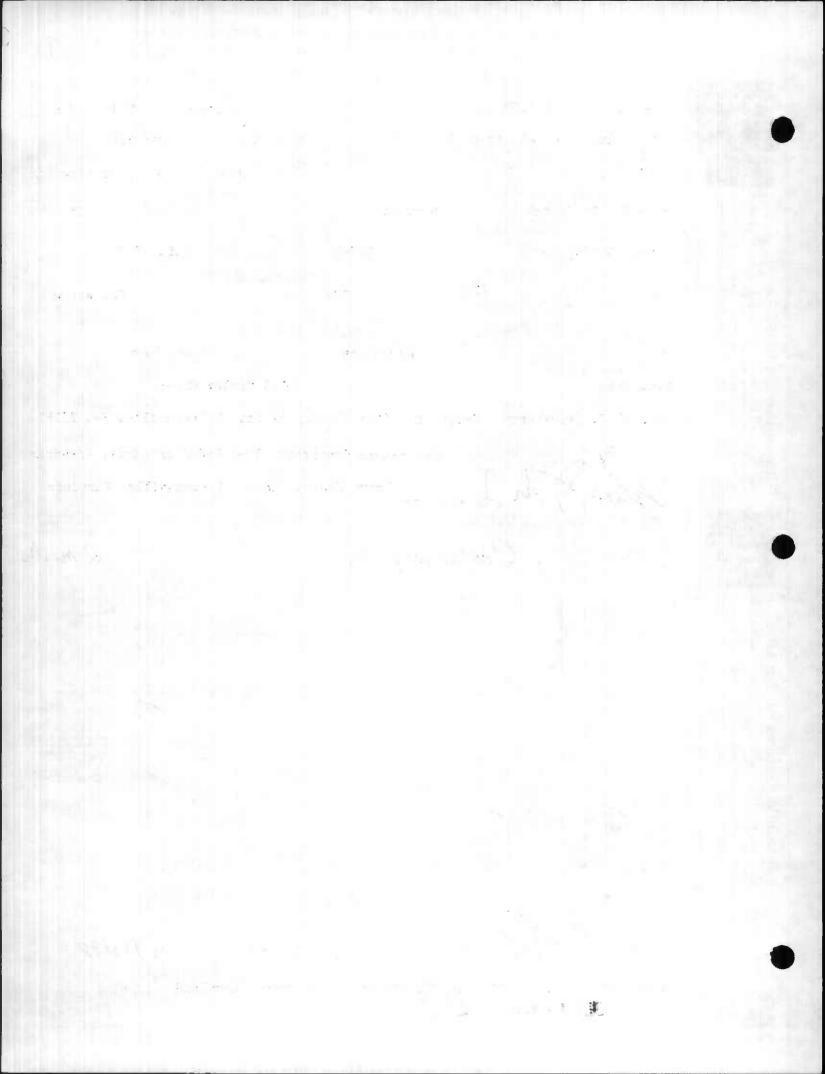
Edward Riuli, M.D. 31. Dete filed (Month 2 8 1998

310 W. 9th. Street 32. Registrants Signeture

2

Frederick, Maryland

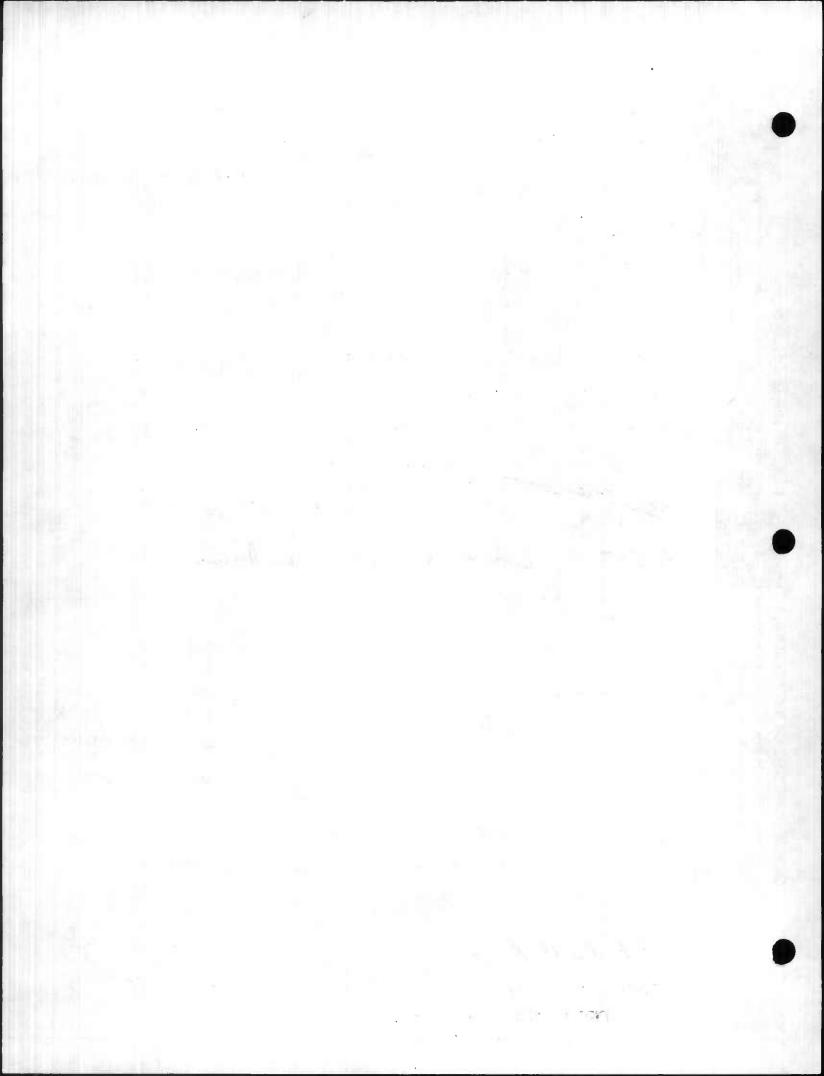
State Registrar



BRYAN K BITTNER

### Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

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	5. Social Security N	lumber	6. Sex		7. Age (In	yrs. last birthda		r 1 Year	If Under 2	4 Hrs.	8. Dete of Birth (Month, Day	Vand	9. Birthp	lace (State or	Foreign
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State of Maryland / Department of Health and Mental Hygiene 98 4 1 69

			C	Certificate of	Death	R	eg. No.	
Discusial and	1. Decedent's Neme (First, Middle, La					2. Dete of Deet Month		3. Time of Death
Physician /Medical		June H	ope But	ler		December	r 25, 19	98 7:15 A.M.
Examiner	4a Fecility Neme (If not institution, give				4b. City, Town, or		4c. County o	
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neral ector		Sex 7. Age	(In yrs. last birtho	Months Devs	Hours Min.	8. Date of Birth (Month, Dey, May 6,	Year)	9. Birthplece (State or Foreign Country) orth Carolina
tor	Usual Residence of Decedent		02			may 0,	1910 1	orth Carorina
	10a. Stete 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
Ş	Maryland Free	derick		F	rederick			1 ☐ Yes 2 No
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wi	nat Country?
	6855 Buttonwood	d Court		2	21703		U.S.	Α.
Funerai	11. Merital Status	12. Wes Decedent En	ver in U,S.	13. Wes Decedent of H	fispanic Origin? (S	pecify Yes or No-		- American Indien, White, etc.
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1 by	3 X Widowed 4 □ Divorced	Yeer or Detes:		1 163 2,4,110	эрвону.		Specify:	White
Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. D	ecedent's Usuel Occup Give kind of work done fe. DO NOT use retired	petion during most of wo	rking	16b. Kind of Bus	iness/industry
1dm	Elementery/Secondery (0-12)	College (1-4or 5+	)	fe. DO NOT use retired Homemaker			Own Ho	ome
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Be			BROWN	T		vie		WAGNER
To	Rozell  19a. Interment's Name/Reletionship	Clima Drintl		Nailing Address (Street			Hope	
	Lynn H. Suter, D			3 Primus Co				_
	20a. Method of Disposition	augnter	20b. Place of D	isposition (Neme of				Sity or Town, State
	1 ☐ Burial 2 🗡 Cremation 3 🛭		cemetery.	cremetory or other plea				ourg, Maryland
	4 Donation 5 Other (Speci		SHITCHS	22. Name end Addre		. 20,1990	DILLTIN	ourg, Paryland
	21. Signature of Funeral Service Lice	11 411		Keenev & F	Basford P	.A. Fune	ral Home	2
	Ollan 7	/ / www	M00703	106 East C	Church st	reet, Fr	ederick.	MD 21701
	23a. Pert1. Enter the disease, or com shock, or heart teilure. List only	one cause on each line	ne death. Do noi	enter the mode of dyir	ng, such es cardie	c or respiretory erro	est,	Approximate Interval Between Onset and Deeth
an al	Immediate Cause (Final	O						0.100( 3.10 2001)
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edical	resulting in death) Last	D	ue to (or as e cor	isequenca oi):				
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hys	Port II. Other significant conditions t	contributing to death but	not resulting in th	ne underlying cause giv	rent ut Pent t.	1□ Y		3 Probably 4 Unknown
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Completed						perfor	1001	completion of cause of death?
mo						10 W	05 2 No.	1 ☐ Yes 2 ☐ No
BeC	25. Was case referred to medical				26. Place of De	ath (Check only on		
To B	examiner?	Hospital:	t 2 ER/Outp	atient 3 DOA Oth	nor:	tome 5 heside	-	(Specify)
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ig	1 Netural 5 Pending investigation	(Month, Day	Year) Inju		rk?  Yes 2∐No			
fica	3 ☐ Sulcide 6 ☐ Could not b	200, Pleca of Injur	y - At home, farm	, street, factory, office		28f. Location (St	treet and Numbe	r or Rural Route Number,
Certification:	4 Homicide	building, etc.	(Specify)	124 2		City or Town	n, Stete)	
	29a. Certifier 1 Certifying Pt	hysician. To the best of	my knowledge, d	leath occur ed at the tir	me, date and place	, and due to the c	ause(3) and man	nei es stated.
edical	(Check only 2 Medical Example)	miner: On the basis of e and manner state	xamination and/o	or investigation, in my o	opinion, death occu	irred at the time, d	late and place, ar	nd due to the cause(s)
Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
		6/4	400 100	2	676		2 2	/ /00%/
	30. Neme end address ot person who	completed cause of de-	oth (Item 23a) (To			,	1000 1	5,1998
	P. Gregory Raus				treet. F	rederick	MD 217	01
tate	31. Dete tiled (Mont ) ( Yes)		- 0:				,	
strar	DLU 4 0	1330	's Signeture	B. So	a. W.			
6/95		7		1 jugar	ales!			

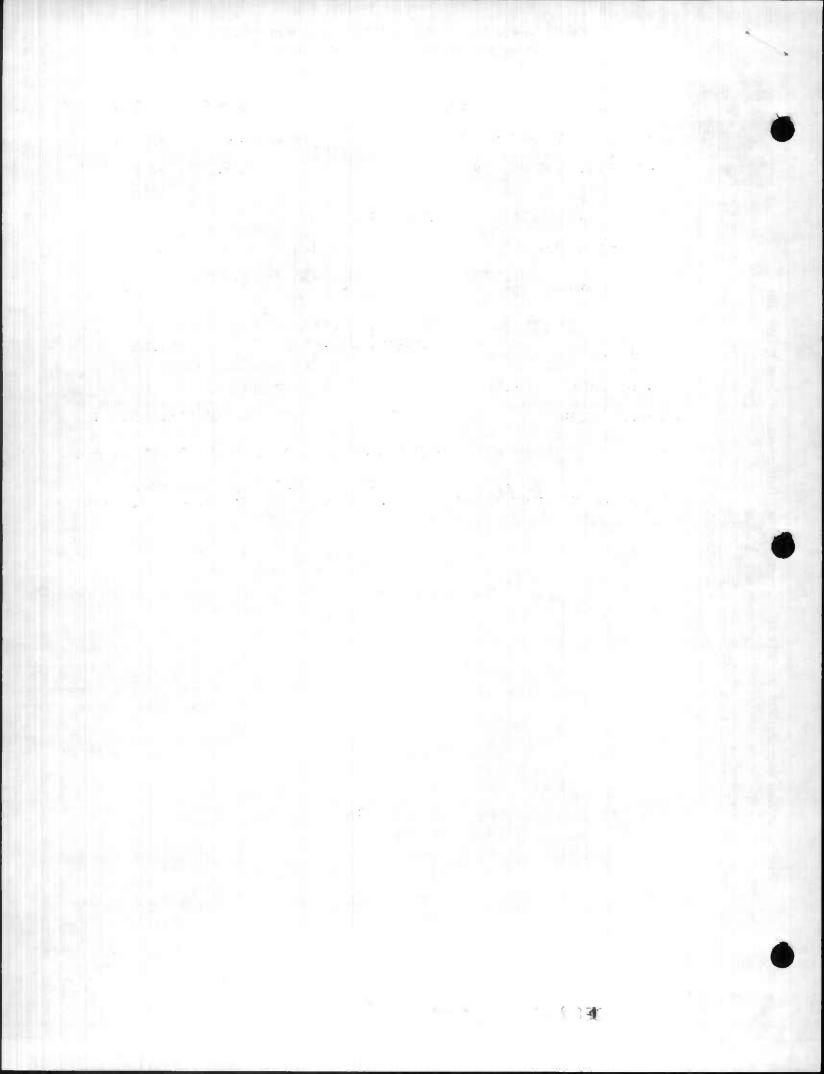


32. Registra's Signetura

Registrar

State

31. Dete filed (Month, Day, Year)



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

21561

1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bottler

20b. Place of Disposition (Name of cemetery, crematory or other place)

GUNSHOT OF CHEST

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or es a consequence of)

Bittinger Family Cem.

22. Name and Address of Facility

Stewart Funeral Home

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

0	1	1	1	-	1
5	1.3		13	1	
				-	

USA

Specify:

18. Mother's Name (First, Middle, Maiden Sumame)

Edna Marie Otto

Date

12/23

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

197 Water Wheel Road, Oakland, Md. 21550

16b. Kind of Business/Industry

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Nes 2 No

SWANTON, MARYLAND

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

1 Yes 2 No

Swanton, Md.

14. Race - American Indian,

White

Approximate Interval Between Onset and Death

Cumberland Water Sales

Black, Whita, etc.

	sician		C
		1.	Deced
B.K.S	ITEMS		#23

State of Maryland / Department of Health and Mental Hygiene PART I, 27, 28A-F PER MEO G769 3-3-99 Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. 19, 1998 5:16 PM lifford Ray Bittinger 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY MEMORIAL HOSPITAL If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1ĂM 2□ F Months Hours Yes Director 218-74-5434 May 2, 1961 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Garrett Swanton 10g. Citizen of What Country? 10f. Zip Code

12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates:

College (1-4or 5+)

Director Funeral by Completed

r 28a-f ma 23a or Nems 2 the Medical

death 72 hours after Hyglene. filed within .. Pages 1 and 2 should be filed vitinent of Health and Mental Hygle tant: If Nem 27 is marked other I jury or other traumatic event, it Department of important: If any injury or pace.

the Maryland

21215-0020

Baitimore, Maryland

**Physician** /Medical Examiner

sician and burial-transit Box 68760. slcian The law requires that the death certificate be physic the b 98 039 0 ۵ been signed be det Records, page 2 Vitai o this funeral Attending Division aftar death. à

10e. Street and Number 573 New Germany Road 11. Merital Status 1 Never Married 2 Merried 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th 17. Father's Name (First, Middle, Last) Forrest William Bittinger 19a. Informant's Name/Relationship (Type, Print) Forrest W. Bittinger/Father 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funetal Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting In death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

by Completed Be Medical Certification: To

3 Suicide

25. Was case referred to medicat examiner? XX Yes 2□ No 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be

4 | Homicide

31. Dete filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

nte

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

IN AN ALL TERRAIN VEHICLE

2:10

28a. Date of Injury (Month, Day Year)

2-19-98

29c. License number O.C.M.E

28c. Injury at Work?

1 ☐ Yes 2 X No

29d. Date signed (Month, Day, Year) 21,1998 DEC.

28d. Describe how injury occurred SUBJECT WAS SHOT

when muzzleloader went off when vehicle struck a fixed object.

28f. Location (Street and Number of Bural Route Number City or Town, State) 603 BITTINGER ROAD

leled cause of death (Nem 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 30. Name and address of person who comple MDrypmons

State Registrar

DEC 2 4 1998

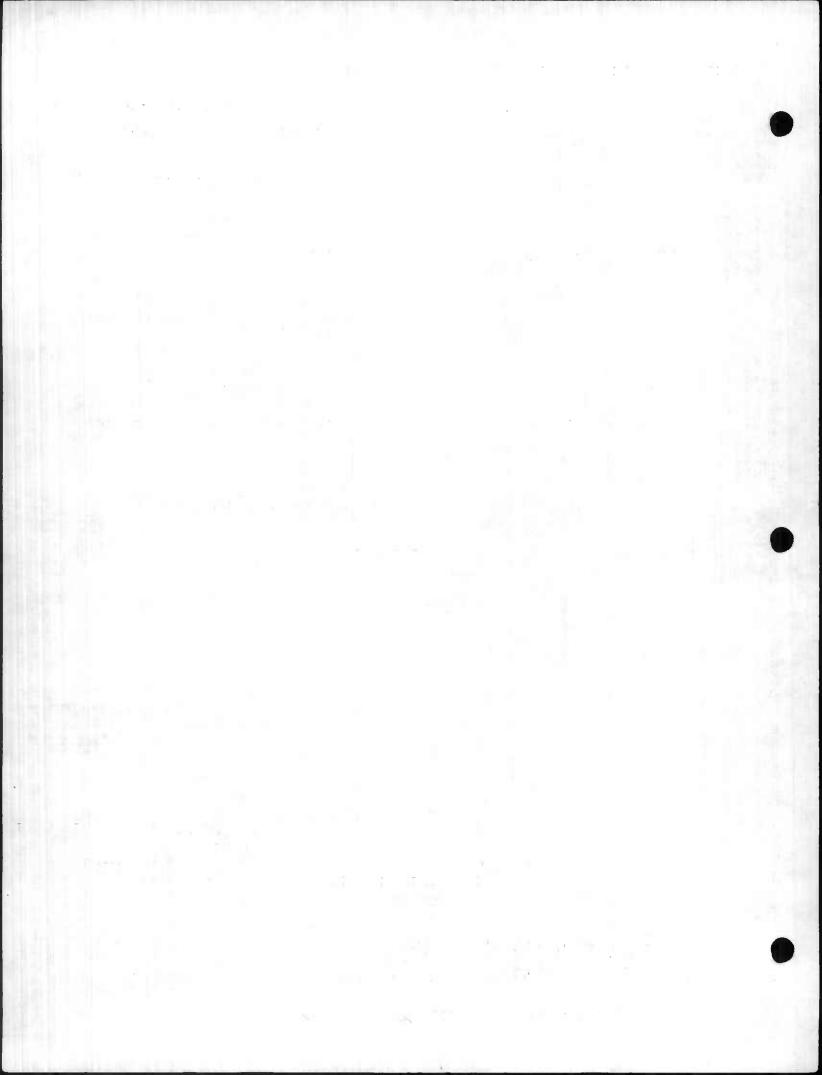
32. Registrar's Signature

6

Hospital 24 hours a Funeral D

To the Hosp within 24 hos To the Fune completely fi

filled in



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 11:50am Mondell Lavernia Brown 12 25 1998 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Oakland Garrett Cuppett & Weeks Nursing Home 5. Sociel Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Dey, Year) 7/27/1917 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 201 Months Deys Hours Min Yrs. Director 81 235-80-1222 WV Usual Residence of Decede the Maryland 10a. Stete to or 28a-f show 10b. County 10c. City, Town or Localion 10d. Inside City Limits Director 1 XYes 2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? with ma 23a 706 E. Adler Street Funeral 21550 death USA items ; 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. the Medical Examiner filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: ŏ 1 ☐ Yes 2√2 No Specify: by White 3 to Widowed 4 □ Divorced Specify: "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 8th i. Peges 1 and 2 should be filed w thent of Heelth and Mental Hygien fant: If Item 27 is marked other ti jury or other treumatic event, to 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Melden Sumeme) Lonnie Shahan Arizona Bolyard 0 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21550 Mildred O'Haver/Daughter 411 Shenandoah Avenue, Mt. Lake Park, MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stele 1 Nurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Pine Run Cemetery 12/28/98 Terra Alta, WV 21. Signature Juneral Service Licenses Arthur H. Wright Funeral Home 105 Highland Avenue 764 recomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. 22. Name end Address of Fecility Approximete Interval Between Onset and Deeth Physician /Medical Immediete Ceuse (Finel reismoni diseese or condition resulting in deeth) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): use as the burial-tra Physician/Medical Due to (or as a consequence of): signed by the a significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes an autopsy performed? Deed hes certificete

**Examiner** 

21215-0020

altimore, Maryland

P.O. Box 68760,

Records,

Division of Vital

this

After Attending

To the Hospital o within 24 hours af To the Funeral D completely filled i

Medical

Be 2 Certification: s after dea.

2 JNo 1 ☐ Yes 2 ☐ No

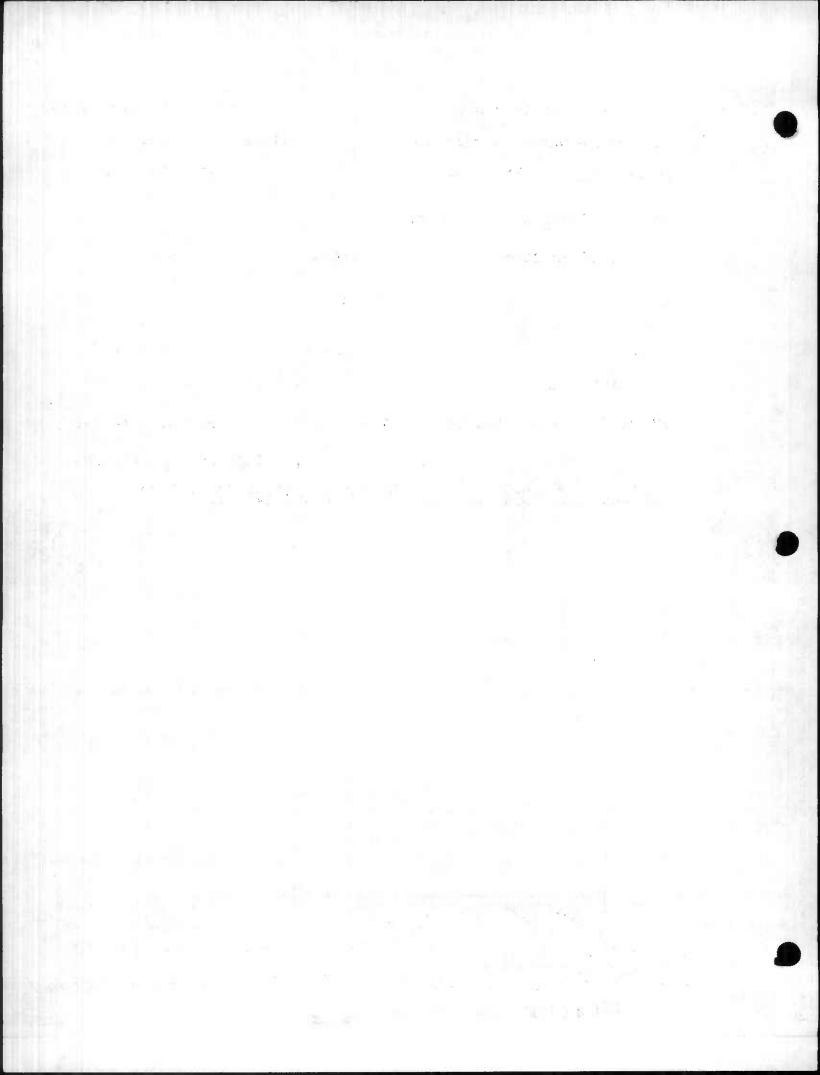
25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 10 Other: 4 Vursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 1 Neturel 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier (Check only one)	∠   Medical Exapprer:	n: To the best of my knowled On the basis of exemination e end menner steted.	ge, deeth occurrend/or investigel	red at the time, date and place, and ion, In my opinion, death occurred	d due to the cause(s) and manner as steted. at the time, dete end plece, and due to the cause(s)
29h Signelure en	d title of certifier		//	20s Lisanes number	20d Data singed (Marth Day Very)

30. Name end address of person who completed cause deeth (ttem 23a) (Typa, Print)

TERRAALTA WU 26764 VOROUL 31. Dete filed (Month 32. Registrar's Signeture

State Registrar 3 0 1998



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month James Lee 21 Cummings December 1998 2:31 AM 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Devs Months 12 M 2 F 09 19 Usuat Residence of Deci 10e State 10b Counts 10c. City, Town or Location 10d. Inside City Limita Frederick Brunswick 1 Yes 2 No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 106 East "A" Street 21716 USA 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11 Meritel Status 1 Yes 2/2/No if Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) B&O Railroad Trainman 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Nettie Violet Evans James Lee Cummings, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent'a Neme/Reletionship (Type, Print) 106 East "A" Street, Brunswick, MD 21716 Many E. Cummings 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Old Brethnen Cemetery 12/23 Brownsville, MD 4 ☐ Donetion 5 ☐ Øther (Specify) 22. N me and Address of Ficility John 1. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716 S Banbana A. Owner Williams, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final diseeae or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or ea a consequenca of) Due to (or ea e consequenca of) Pert II. Other significant conditions contributing to deeth but not cesulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an eutopsy performed'

Physician /Medicai Examiner

ò

any injury

**Physician** 

/Medical

Examiner

MD

Director

Funeral

à

Completed

Be

**Funeral** 

Director

tem 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mentel thygiene. Important: If Item 27 Ia marked other than "natural", or Ite

altimore, Maryland 21215-0020

with the Marylend

the burial-transit and attending physician for use as the buna signed by the at peen page 2 has certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

lew requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical by Completed funeral director, Be Certification: To

1 TYes

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 □ Yas 2 □ No

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signeture and title of cartifler

1 Avatural

3 Suicide

29e. Certifier

4 | Homicide

Certifying Phyalcian: To be best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner as steted.

2 Medical Examinar: On the resist of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end piece and piece, and due to the cause(s) end piece and piece.

29c. License number

29d. Dete signed (Month, Day, Year)

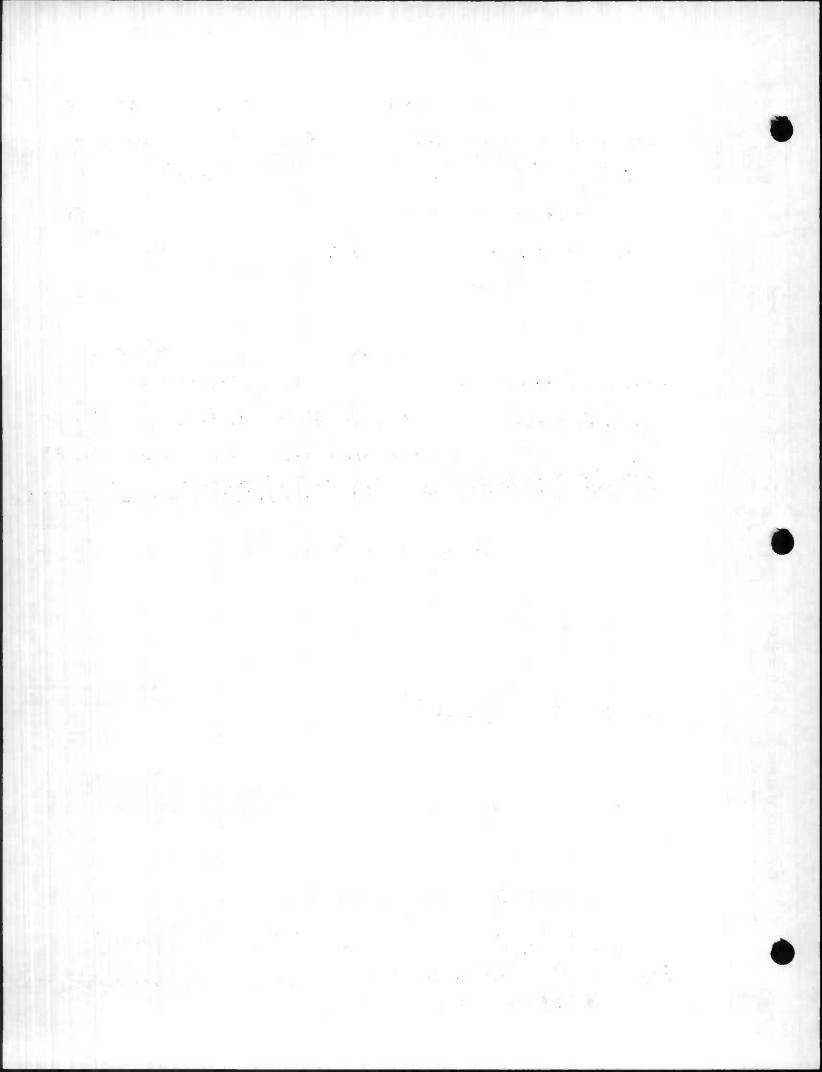
30. Name end addre use of deeth (Item 23e) (Type, Print) Ma

1998 Registrer Signeture 31. Dete filed (Month,

State Registrar

edicai

To the Hospital within 24 hours a To the Funeral Completely filled



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Data of Death 3. Tima of Death Day **Physician** 25, 1998 4c. County of Death Robert CLISER Lee December 5:15 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Frederick Memorial Hospital Frederick Frederick 8. Data of Birth (Month Day, Year) April 16, 1941 If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (Stata or Foreign Country) West Virginia 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours Min 57 Yrs. 233-66-6994 Director Usual Rasidance of Dacedani 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or flerns 23a or 28a-f show traumatic event, the Medical Examinat must be not lifted at 1 Nas 2 No Maryland Frederick Frederick Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda pemit. Peges 1 and 2 should be filed within 72 hours efter death v. Department of Haalth end Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23a eny injury or other traumatic event, the Medical Examples mans once. 408 Columbus Avenue 21701 U.S.A. Funeral 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian Black, Whita, atc. 1 Tyas 2 No 1959 H Yas, Giva Yaar or Datas: 1965 1 ☐ Navar Marriad 2 ☐ Married to 1□ Yas 3₽ No Specify: Specify: White þ 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 18b. Kind of Businass/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) Business Manager State Government 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Robert Martin Cliser Alice Mae Dawson 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mary Helen Cliser/wife 408 Columbus Ave., Frederick, MD 21701 20b. Place of Disposition (Nama of competary, cramatory or other place)
Smithsburg Crematory Dec. 30, 1998 Smithsburg, Maryland 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 Donation 5 Other (Specify) ra of Funaral Sarvice Licensas 22. Nama and Addrass of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part1. Entar tha disease, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disaasa or condition rasulting In daath) /Medical 4 motities **Examiner** Physician/Medical Examiner attending physician and for use as the buriel-transit Sequantially list conditions, it any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants Due to (or as a consequence of) Dua to (or as a consequance of): rasulting in death) Last Pert II. Other algorificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Brobably 4 ☐ Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 20] 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 28d. Describe how Injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28a. Data o rjury (Month, Day Year) Certification: 5 Panding invastigation Accident 1 ☐ Yas 2 ☐ No 6 ☐ Could not be 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida edical rtlifying Physician: To tha best of my knowledge, deeth occurred at the time, deta and place, and dua to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the deeth certificate be executed Division of Vital Records, peed has certificate Physician: this funeral After or Attending s after dea.

\*I Director: An in by the fur filled in within 24 hours a To the Funerel C completely filled Hospital

the

P.O. Box 68760.

with the Maryland

Baltimore, Maryland 21215-0020

28a-f show

Registrar

31. Data filad (Month, Day, Year) **DEC 2 8 1998** 

29b. Signatura and title of certifie

30. Neme and add

es of person who complated ceuse of daeth (Itam 28e) (Type, Pr

29c. Licansa number

29d. Data signed (Month, Day, Year)

Philip Shapiro, M.D., 814 Toll House Ave., Frederick, MD 21701 32. Registrar's Signatu

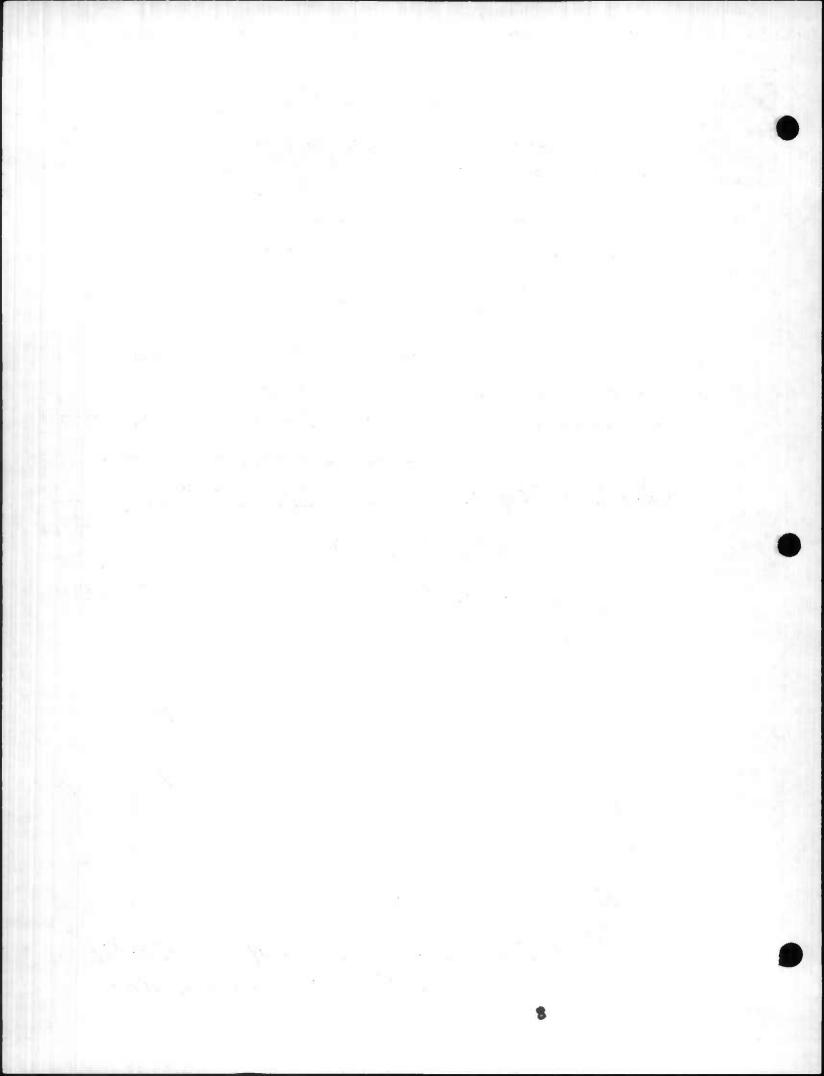
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State of Maryland / Department of Health and Mental Hygiene

				_	Certificate of	M 0 01 11 1		Reg. No.			
		. Decedent's Neme (First, Middle, Last)					2. Dete of De	eeth	W	3. Time of Death	1
ian cal		Jame	s Ar	thur	CUTSA	IL, JR.	Month	ember 2	25, 199	8 12:25	1
ner		a. Fecility Neme (If not institution, give street a	and number)			4b. City, Town,	or Location of Deet		inty of Death		
		Citizens Nursin	g Home of	Frede	erick Co.	Frede	rick		Free	derick	
	6	. Sociel Security Number 6. Sex	7. Age (In yrs.	last birthd	(ey) If Under 1 Yee Months Deys	If Under 24 H		16, 19	9. Birth	olece (Stete or Fore	ign
		215-26-8267 15xM 2	90	Yrs	3.	110010	April	16, 19	908	"'Marylan	a
	-	Jsuel Residence of Decedent  0a. Stete 10b. County	10c Cit	ty, Town or	r Location				1.	Od Inolda City I Inc	
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ecto		Maryland Frederic	k		Frede	erick					-
ā		0e. Street end Number	n 4		10f. Zip Code	217	2		U.S.A		
Funeral Director		1080 Rocky Springs	the same of the sa	0	10.111						_
un.		Arr	es Decedent Ever In U. ned Forces?	,S. 1	<ol><li>Wes Decedent of tf Yes, specify Cu</li></ol>	Hispenic Origin? ben, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		Rece - Americ Bleck, White,		
by F		The state of the s	Yes 217 No		1□ Yes 2□ No	Specify:		Spe	city:	White	
Pa	-	15. Decedent's Education	er or Detes:	160 Do	ecedent's Usuei Occi			16h Kind a			
Completed		(Specify only highest grade comp		(G	ive kind of work don	during most of v	vorking	Tob. Kind o	f Business/In	dustry	
E		Elementery/Secondery (0-12) Co	liege (1-4or 5+)			-,		Fs	arming		
O		7. Father's Neme (First, Middle, Last)		ra	rmer	18. Mother's N	lame (First, Middle				
To Be		James A. Cutsail	Sr			Grac	e A. Bake	or			
-		9e. Informent's Neme/Relationship (Type, Pri		19b. M	lelling Address (Stree				wn. Stete. Ziu	Code)	
	1	Ruth E. Cutsail/Wife			080 Rocky			-			
	-	0e. Method of Disposition	20b. P		isposition (Neme of		Dete		on - City or To		_
	20e. Meth			lace of Di			-0.0				
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		4 Donetion 5 ☐ Other (Specify)	Fre	ederi	ck Memoria 22. Name end Add Keeney &	al Park ress of Fecility Basford	Dec. 29, Funeral	1998 Home	Fred	D 21701 Approximete Intervel Between	
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State Registrar

Frederick, MD 21701



### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

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State of Maryland / Department of Health and Ment	al Hygiene	98	4	13	7	6
28A-F PER MEO Certificate of Death	Reg. No.					

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last) BOYD LEE COOPER

DECEMBER 28 1998 4b. City, Town, or Location of Death

3. Time of Death 1534 P

**Funeral** 

must be notified at

"natural", or Itema 23a or

Hyglene.

Pages 1 and 2 should be filed vent of Health and Mental Hyglemt: if Nem 27 is marked other 1

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

by

Completed

Be

Certification: To

edicai

GARRETT MEMORIAL HOSPITAL 5. Social Security Number

4e Facility Name (If not institution, give street and number)

OAKLAND. If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday)

4c. County of Death GARRETT

233-70-0055 Usual Residence of Decedent

110 M 2□ F 57

Days Months Hours

10f. Zin Code

8. Date of Birth (Month, Day, Yea OCT 1, 19 Year) 1941

2. Date of Death

9. Birthplace (State or Foreign Country) MARYLAND

10d. Inside City Limita

1 Yes 2 No

Director

the Manyland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

10a State 10b. County MD GARRETT

OAKLAND

Yrs.

10c. City, Town or Location

10e. Street and Number

11 Marital Status

3851 CRANESVILLE ROAD

21550 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA 14. Race - American Indian, Black, White, etc.

10g. Citizen of What Country?

1 Never Married 2 Merried 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes:

1 ☐ Yes 2 No Specify:

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

OAKLAND, MARYLAND

Elementery/Secondary (0-12)

College (1-4or 5+)

BUS BOY

RESTAURANT

17. Father's Neme (First, Middle, Last)

SYLVANAS

COOPER

MAE VTOLA

18. Mother's Neme (First, Middle, Maiden Sumame)

12/31/98

PARKS

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12400 BLADES RD.

CORDOVA, MD 21625

THEODORE TRUBAN - BROTHER

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

B.

20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CEMETERY

Date 20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

P.O. BOX 243

M00167 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

DURST FUNERAL HOME - OAKLAND, MD 21550 Approximate Interval Between Onset and Death

**Physician** /Medical **Examiner** 

and

the

signed by the

page 2

this

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Finel disease or condition resulting in deeth)

MULTIPLE INJURIES Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or es a consequence of)

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 DYes 2 No 1 □ Yes 2 □ No

25. Was case referred to medical axaminer? 1X Yes 2 No 27. Menner of Death

5 Pending investigation 6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient ※IX DOA 28a. Date of Injury (Month, Day Year) 12-27-98 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b Time of 28c. Injury at Work? P 1 Yes 2 No 5:15

28d. Describe how injury occurred

26. Place of Death (Check only one)

DRIVER OF CAR RAN OFF ROAD 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) CRANESVILLE RUAD.

GARRETT COUNTY, MD.

111 Penn Street, Baltimore, Maryland 21201

29e. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pw

ROAD

O.C.M.E

29c. License number

29d. Date signed (Month, Day, Year) DECEMBER 29, 1998

HARGARIA 31. Dete filed (Month, Day, Year)

DEC 3 0 1998

32. Registrar's Signeture

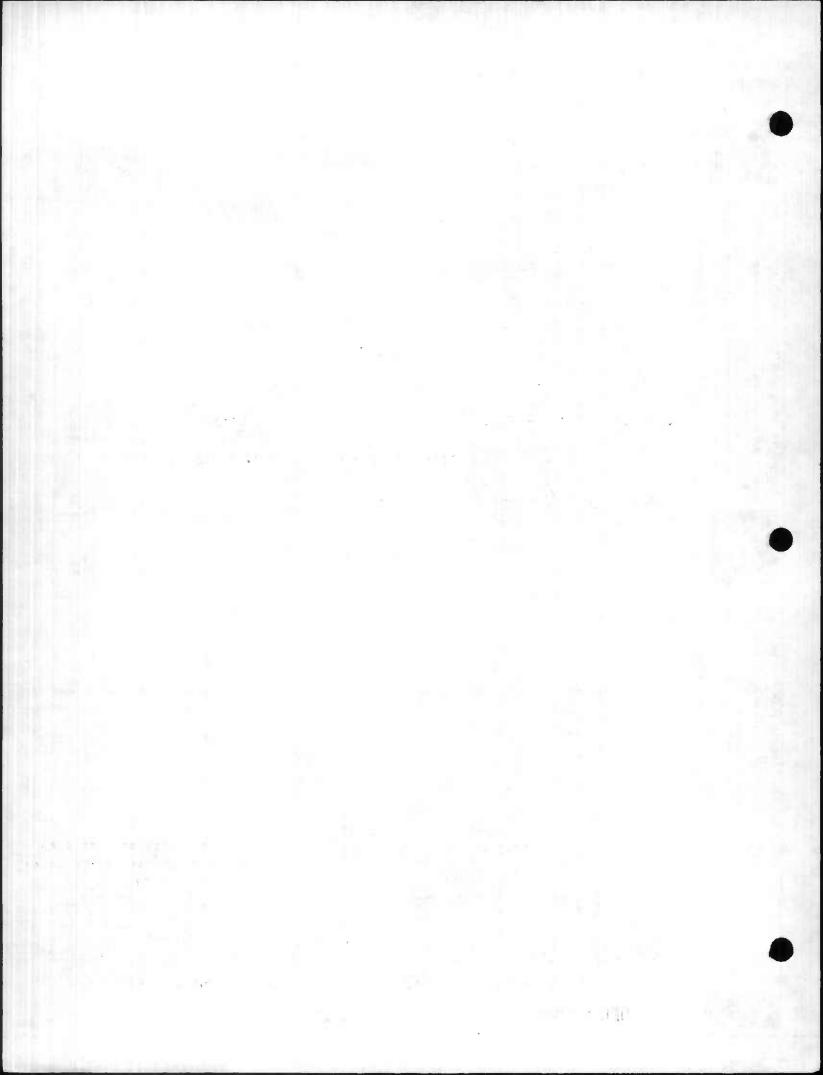
. Korloh

Registrar **DHMH 16 Rev 6/95** 

Box 68760 P.O. Records, Division of Vitai

Attending death. after death Director: 6 To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State



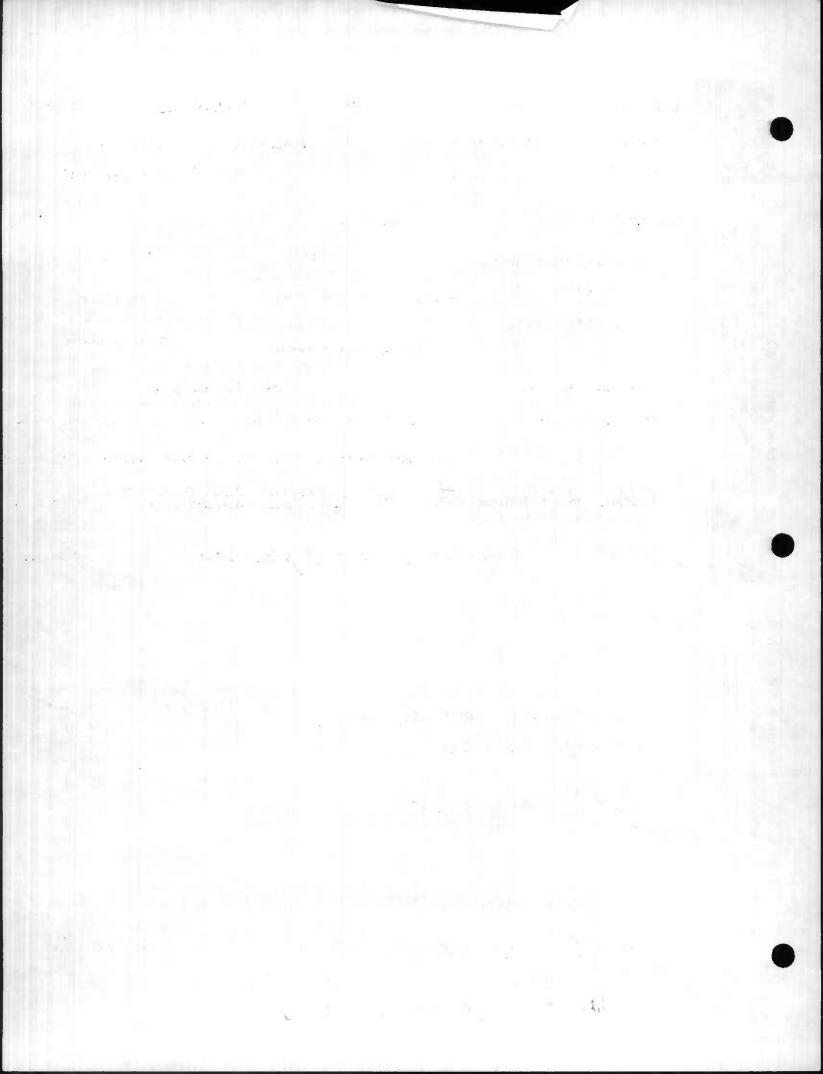
### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State c	of Mary	land / [	Depa	artme	nt of	Heal	th and	Mental	Hygiene
			_						

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death **Physician** DAY 11:58 AM LEE DECEMBER KENNETH 25,1998 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Undar 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1 M M 2 □ F Birthplace (State or Foraign Country) **Funeral** Min. Months Days Hours Yrs. 514-32-2590 68 Director June 26, 1930 Maryland Usual Rasidance of Decedant 10a State 10b. County 10c, City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Directo Maryland Frederick Ijamsville 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 21754 U.S.A. Funerai 11420 Meadowlark Drive permit. Peges 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other trainments. 12. Was Decedant Evar in U,S.
Armed Forcas?

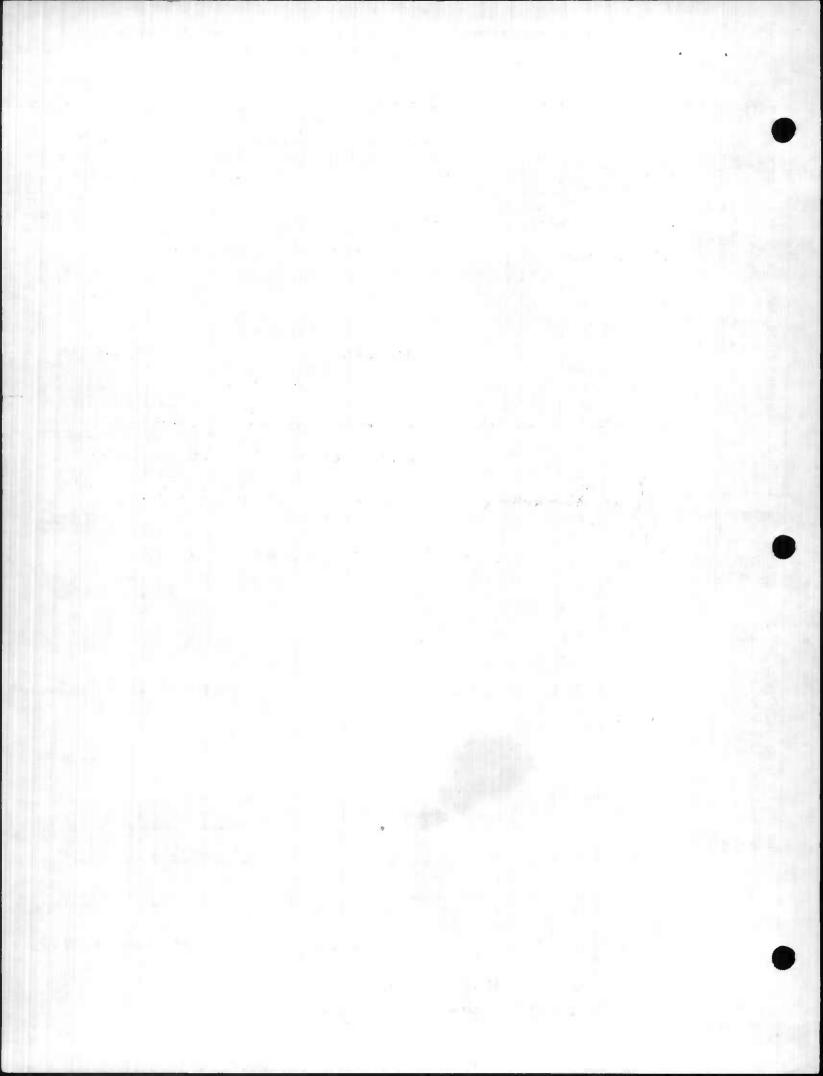
1 ⊠ Yas 2 □ No
fl Yes, Giva
Yaar or Dates: 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 1 Never Married 2X Married 1 ☐ Yas 2 ☑ No Specify: Korea Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantery/Secondary (0-12) College (1-4or 5+) U.S. Government Storekeeper Foreman 11 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Murray D. Day Lois E. Burdette 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) Rowena Day - Wife 11420 Meadowlark Drive, Ijamsville, Maryland 21754 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Bethesda Methodist Cemetery 12/29/98 4 ☐ Donation 5 ☐ Othar (Specify) Damascus, Maryland 21. Signature of Fynaral Sarvice Licensee 22. Nama and Addrass of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland deusa on each lina. 20872-0117 23a. Part1. Entar tha disaase, or complica shock, or heert failure. List only ona Approximata Intarval Between Onset end Death **Physician** failure /Medical Immadleta Causa (Final diseasa or condition rasulting in death) Examiner Examiner physician and s the burial-trans Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of): Box 68760 Physician/Medical Due to (or as a consequance of): use 0 Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? ed by the a P.O. signed by t t ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 has 1 Yes 2 Pin 1 ☐ Yes 2 ☐ No. certificate Division of Vital Hospital or Attending Physicien; director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred Certification: After 5 Panding Investigation 1 Natural after death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) 4 Homicida 24 hours a 1 Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, deta and placa, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta end place, and dua to the cause(s) and mannar stated. edical 29a. Cartiflar (Check only one) within 2 To the 29b. Signature and title of certifies 29c. Licansa number 29d. Date signed (Month. Dav. Year) 30. Name and addrass of person 23e) (Type, Print) 300 w 9th St, Frederick, MD 32. Ragistra 's Signatura 31 Date filed /Month Registrar



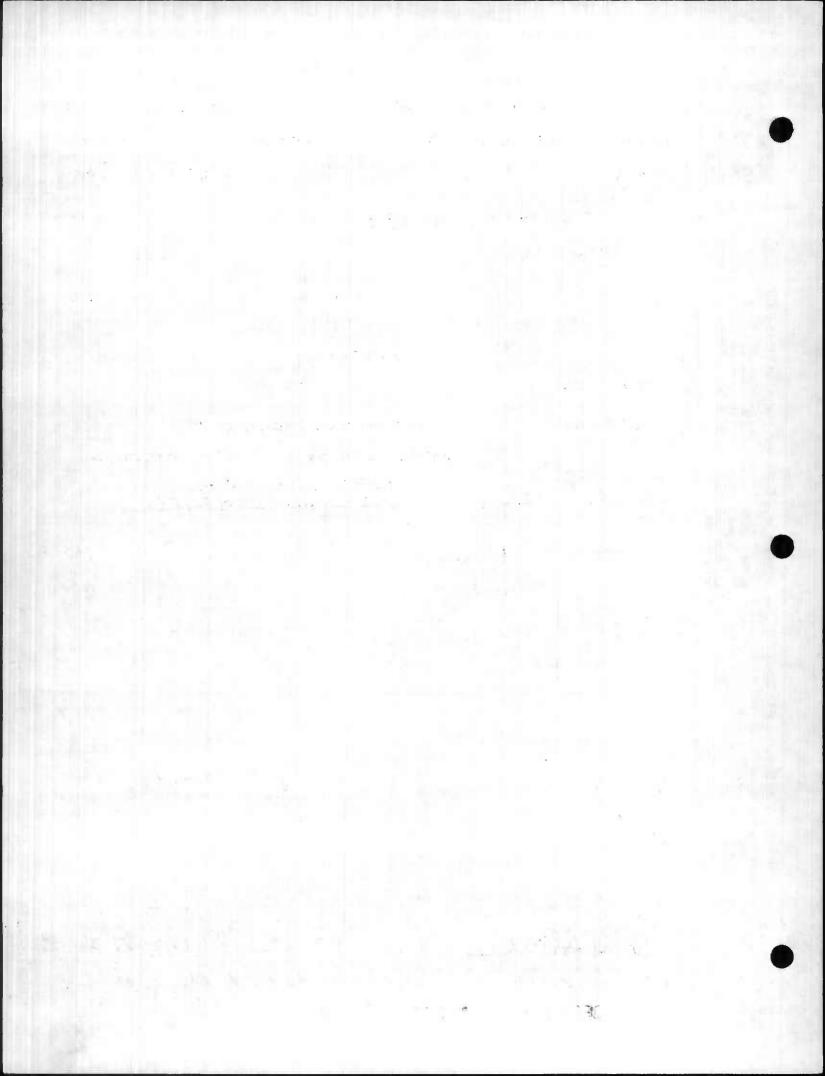
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 4 4 7 8 Item#10b per FH G767 1/19/99 450 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** BERNARD Preston 0623 DECEMBER 26,1998 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CARROLL SYKESVILLE SYKESVILLE CONTINUUM CARE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11/14/1910 6. Sex 1 M 2 F 5. Social Security Number 7. Age (in yrs. lest birthday) Birthplece (State or Foreign Country) 705-12-4979 88 Director Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other treumetic event, the Medical Examiner must be notified at Howard 1 ☐ Yes 2 No Carroll Director Md. Mount Airy 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 21771 17360 Frederick Road U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No It Yes, Give Yeer or Dates: permit. Peges 1 and 2 should be filed within 72 hours effer dea. Department of Health and Mentel Hygiene. Important if flem 27 is marked other there any Injury or other trauments. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White þ 3 DWidowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 0 Construction Carpenter 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Lest) Sadie E. Hickey Wayman Duff 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Clyde Boone/Personal Rep. 7322 Woodbine Road Woodbine, Maryland 21797 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State St. John's Cemetery 12/29/98Ellicott City, Md. 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Fecility Jeffrey N. Zurbrun Funeral Home 6028 Sylvesville Road Eldersburg, Maryland 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) CONGESTIVE HEART FAILURE /Medical **Examiner** Examiner physician and the bunal-trensit the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown OPD P 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was en autopsy parformed? Completed certificate has 1 ☐ Yes 260No or Attending Physicien: after deeth. Director: After this certifica 25. Was case referred to medical exeminer? Be 28. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 20 funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examtner: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) DECEMBER 26, 1998 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 2 AVI NHC, BALTO, State Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 16.15 December 21, 1998 BARBARA ANN FRYE /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 800 Motter Avenue Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ff Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2□XF Months Deys Yrs. Director 218-34-3702 Oct. 12, 1937 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow adical Examiner must be notified at 1 XYes 2 □ No Frederick Frederick Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Experiments and 2005. 800 Motter Avenue 21701 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: by White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Grayson Martin Miss Mary Lee Johnson 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary A. Miss (Sister-in-law) 350 East 3rd Street, Frederick, Maryland 21701 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete Smithsburg Crematory 12/8/98 Smithsburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) of ral ervi 22. Name end Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Pent Enter the disease of implications that a Ved the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the within 2
To the f 29c. License number A Hussan M.D 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 046861

Registrar

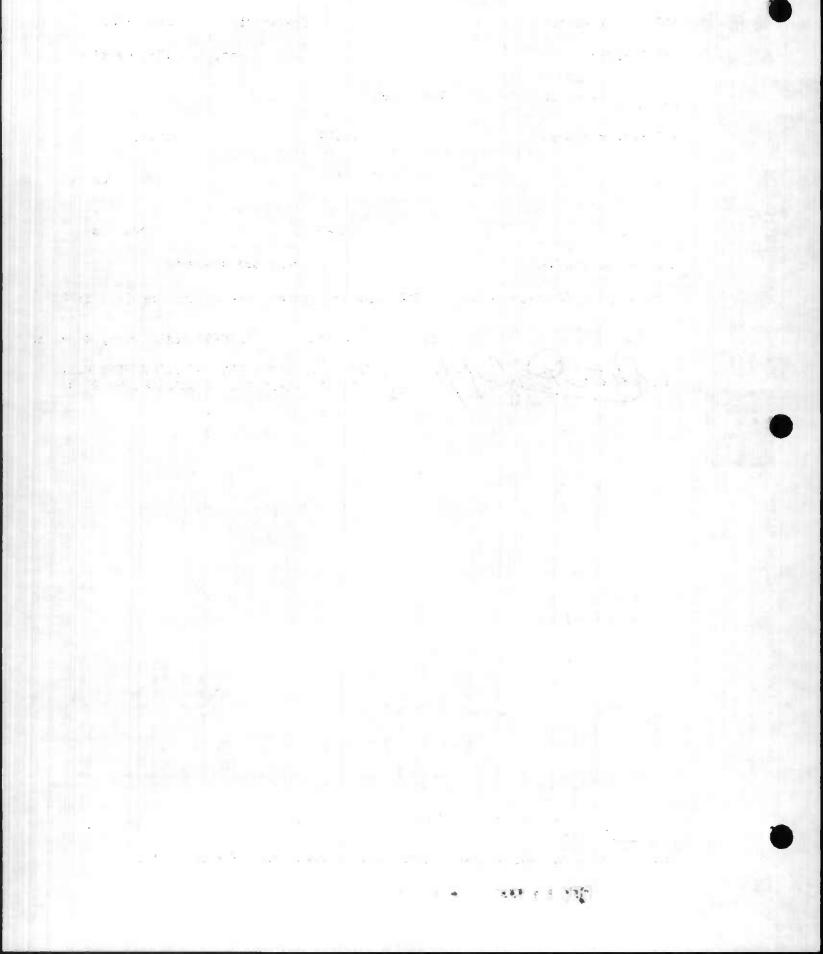
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Naaz Hussain, MD



Naaz Hussain, MD 195 Thomas Johnson Drive, Frederick, Maryland 21701

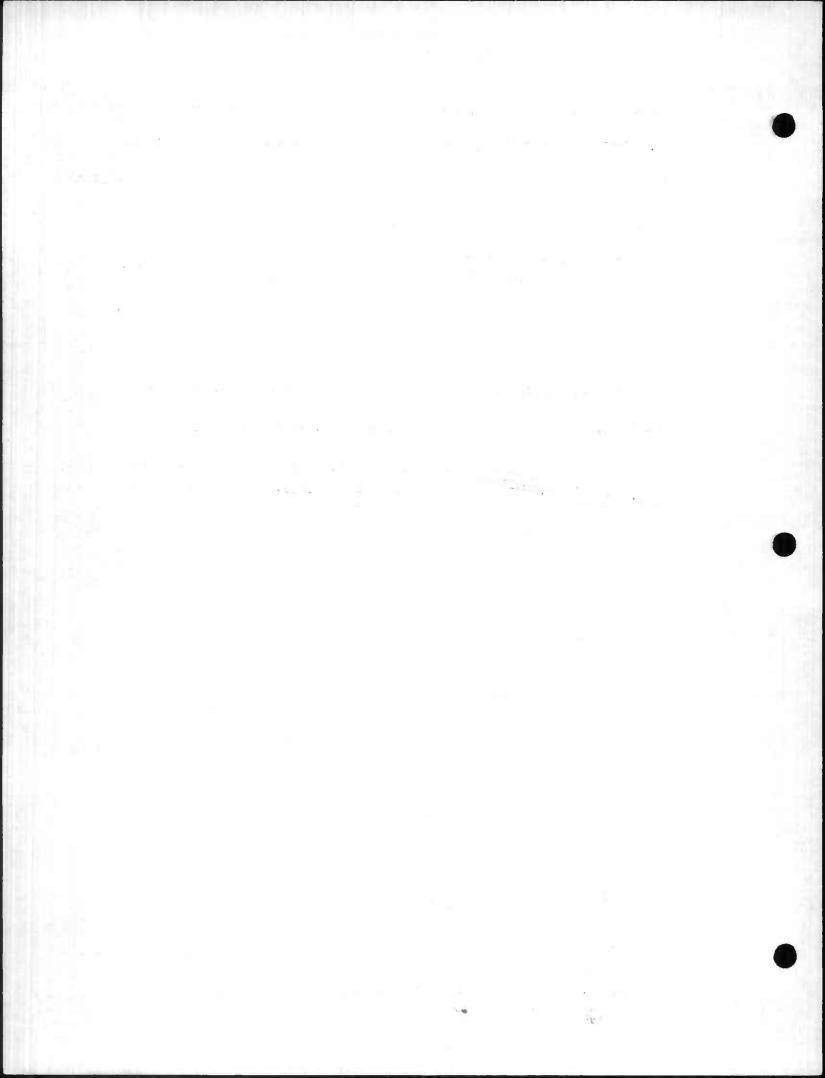
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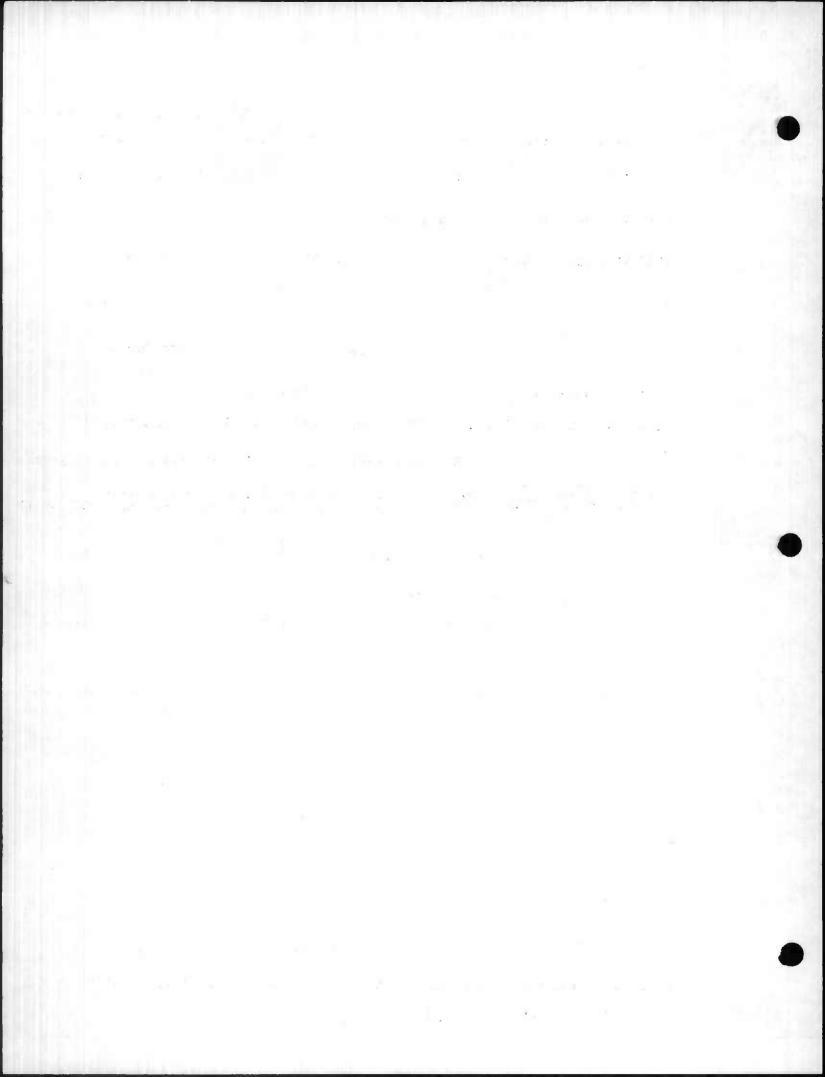
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any injury or other traumatic event, the Madical Examples must be notified at once.  To Be Completed by Funeral Director	11. Maritei Status	12. Wes Decedent Ever Armed Forces?	n U,S. 13	. Was Dec	edent of I	Hispanic Orig	in? (Speci	ify Yes or No- ican, etc.)		e - America	
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To B	William Richa	rds				Blan.	che W	leakley			
-	19a. Informant's Name/Relationship		19b. Me	iling Addres	s (Street			Route Number,	City or Town.	Stete, Zip (	Code)
	Florence V. Fell			-				Monro			
	20a. Method of Disposition		b. Place of Dis	position (Ne	me of				0c. Location -		
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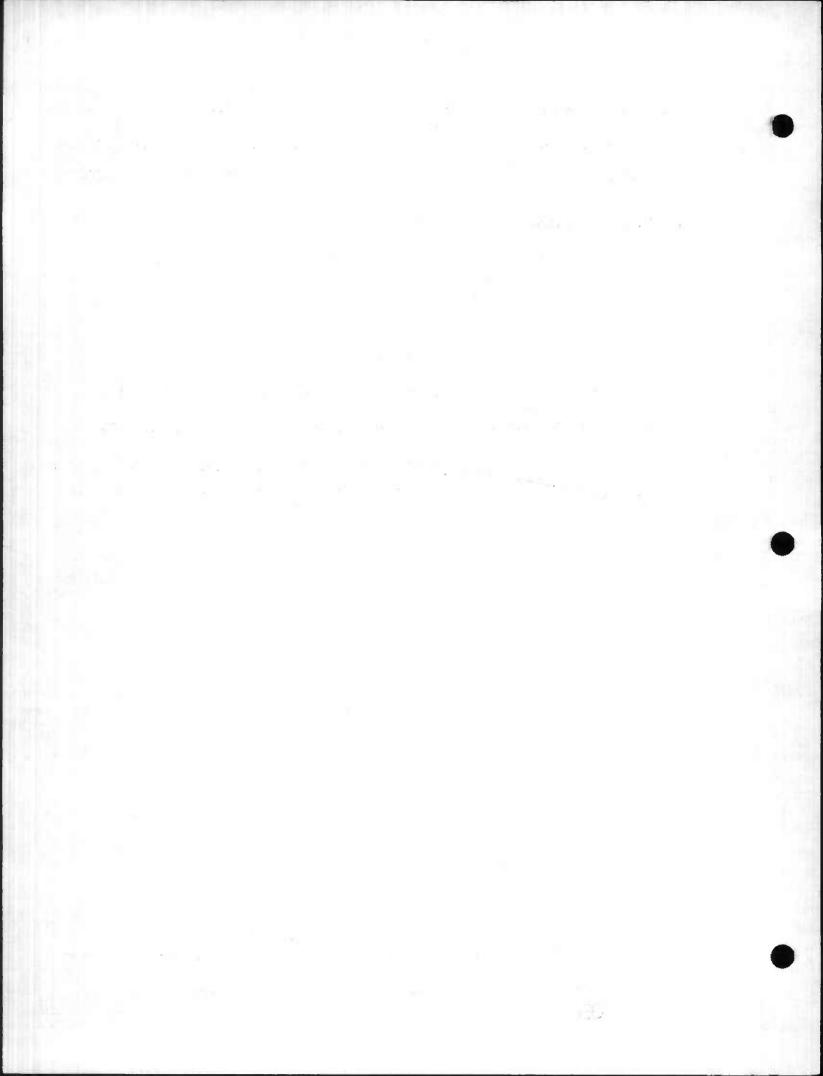


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State of Maryland / Department of Health and Mental Hygiene Q Q

		Decedant's Neme (First, Middla, L.	net)		Certifica	te of	Death	2. Data of Deeti	g. No.		3. Time of Death
Physic	ian		TIE	GIFFT				Month	Dey 1998	Year	8:30am
/Med		4a. Facility Name (If not Institution, gi					4b. City, Town, or Lo				o: Juani
Exami	ner					İ			4c. County		
		423 NORTH CHURO 5. Social Security Number 8.		ge (in yrs. last b	intholous   If I Inde	r 1 Year	THURMONT  If Under 24 Hrs.			ERICK	(0)
Funeral Director			1□M 2⊠F	82	Yrs. Months			8. Data of Birth (Month, Day, JAN 16	Year) , 1916	Country MAR	ce (Stete or Foreign
and land		10a. Stata 10b. County		10c. City, Tov	vn or Location					100	I. Inside City Limits
4 sh	0	MARYLAND FREDERI	CK	THURMO	NT						1 ☐ Yas 2 ☐ No
the the	9	10e. Street and Number	. CR	THORAN		p Code		10	og. Citizen of \	What Countr	0
Find a series	ō	422 NODELL CHILD	or om								
eath 23	era	423 NORTH CHURC	12. Wes Decedent	Ever in U.S.		1788		acity Vas or No-	U.S.A.	e - Americar	indian
21215-0020  d within 72 hours effer death with the Meryland plene. In than "natural", or flerns 23a or 28a-f show in the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Merried 2 ☐ Merried 3 🖾 Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 If Yas, Give Year or Datas:				Hispenic Origin? (Spoan, Mexicen, Puerto Specify:	Ricen, atc.)		ck, Whita, at	c.
Pon Pon Pon Pon Pon Pon Pon Pon Pon Pon	8	15. Decedent's B		164	Decedent's Us	iel Occu	nation		18b. Kind of B	WHIT	
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arylan should be nd Mental marked o	ToB	CHARLES HENRY	HARRISON	STITEL	Y		ESTHER	FLORE	NCE	CARTY	
IOCE, Maryland ges 1 end 2 should be file if of Health and Mental Hy if flem 27 is marked oth or other traumatic event	-	19a. Informant's Name/Relationship				s (Stree	et and Number or Run				
end 2		CAROLYN K. SHAR	FR (DAUGHT	ER) /	23 NODTI	СП	URCH ST.,	типриом	T MD	71700	
is 1 end of Health Health other tr		20a. Method of Disposition	DR (DROGHI	20b. Place	of Disposition (Ne	me of			20c. Location -		n, Stata
Pages nent of net: If the iry or o		1X Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Speci			ery, cremetory or						
		21. Signeture of Funeral Sarvice Lice		RESTHA	VEN MEM	DRIA	L GARDENS ess of Fecility	12/29/9	8 FREI	DERICK	, MARYLAN
Balt permit. Department imports any inje					ROBERT	E.	DAILEY &	SON FUN	ERAL HO	DMES,	P.A.
		14/1			615 EA	ST	MAIN ST.,	THURMON	r, MD		
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Physician /Medical		Immediate Cause (Final	0	0	0 1					1	Anset and Death
Examiner	н	Immediata Causa (Final disaasa or condition rasulting in daath)	· Kor	ral,	Dail	111	e			1	6 mg
	-			Dua to (or as a	consequence of					i	
D #	olu olu		b. 1-1P.	elt	- 11	ali	458			3	Oylar
and Frank	хал	Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaase or injury that initiated evants	1,11	Dua to (or as a	consequence of	:	/				/>
60, be es	a E	cause. Entar Undarlying Cause (Disaase or injury	o. H. If	erts	me ,	0-2	^			1	SORGS
68760, tificate be executed g physician and as the burial-transit	edical Examiner	that initiated evants rasulting in daath) Last	1171	Due to (or as a	consequence of)					-	
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Box eeth cert ettendin for use	lan										
II Records, P.O. Box The law requires that the deeth cer ate has been signed by the ettendir page 2 should be detached for use	Physician	Pert II. Other significant conditions	contributing to death b	out not resulting	in the undarlying	causa gi	iven in Part I.	23b. Did to	bacco usa co	ntribute to t	he cause of death?
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Records,	Completed	America			/			24a. Was ar perform		avaii	autopsy findings able prior to
Reco	ple	TI WOUNTED								of de	olation of ceusa ath?
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Division of Vital or Attending Physicien: T after death. Director: After this certificat I in by the funeral director, p.	10	examiner? 1 ☐ Yes 2K No	Hospital:	ent 2 ER/O	utpatient 3 D	OA Ot	thar: 4 🗆 Nursing Ho	me 5 🔀 Resida	nce 8 🗆 Oth	ar (Specify)	
g Physerthis		27. Mannar of Death	28e. Data of Inju		Tima of	28c. Inju		28d. Describe ho			
nding ath.	atio	1 ☑ Natural 5 ☐ Panding 2 ☐ Accident investigation		y rear/	Injury M		Yes 2 No				
Division or Attendiate death. Director: A lin by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be datarmined	28a. Piece of in	ury - At home, f	arm, street, fecto	y, office		28f. Location (Str		er or Rural I	Routa Number,
de de de	ert	4   nomicide	building, at	c. (Specify)				City or Town	, Stara)		
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a, Certifiar 1∑ Certifying Pl (Check only one) 2 ☐ Medical Exa	nysician: To the bast miner: On tha basis o and manner st	t axamination ar	a, daath occurred nd/or invastigation	at tha ti	ima, data and place, opinion, daath occurr	and due to tha ca red at tha tima, da	use(s) and ma ita and place,	annar as stat and dua to ti	ed. he cause(s)
of the of	Me	29b. Signature end title of certifiar		10-1	29	c. Licen	sa number	29	d. Data signe	d (Month, Da	ay, Year)
8484		Bru Lo	h .		0 4	-4	44001/				
		- poryage	rem	DL-	roy/89	CI	10	DI	ECEMBER	28,	1998
		30. Nama and addrass of person who		,							
		Bonita J. Portie		3	10 S. SE	TON	AVE., EMM	IITSBURG,	MD 21	727	
Sta Regist	ate rar	31. Date tiled (Month, Day Year)	0 1998 N	er Signatura	1. 4		/				
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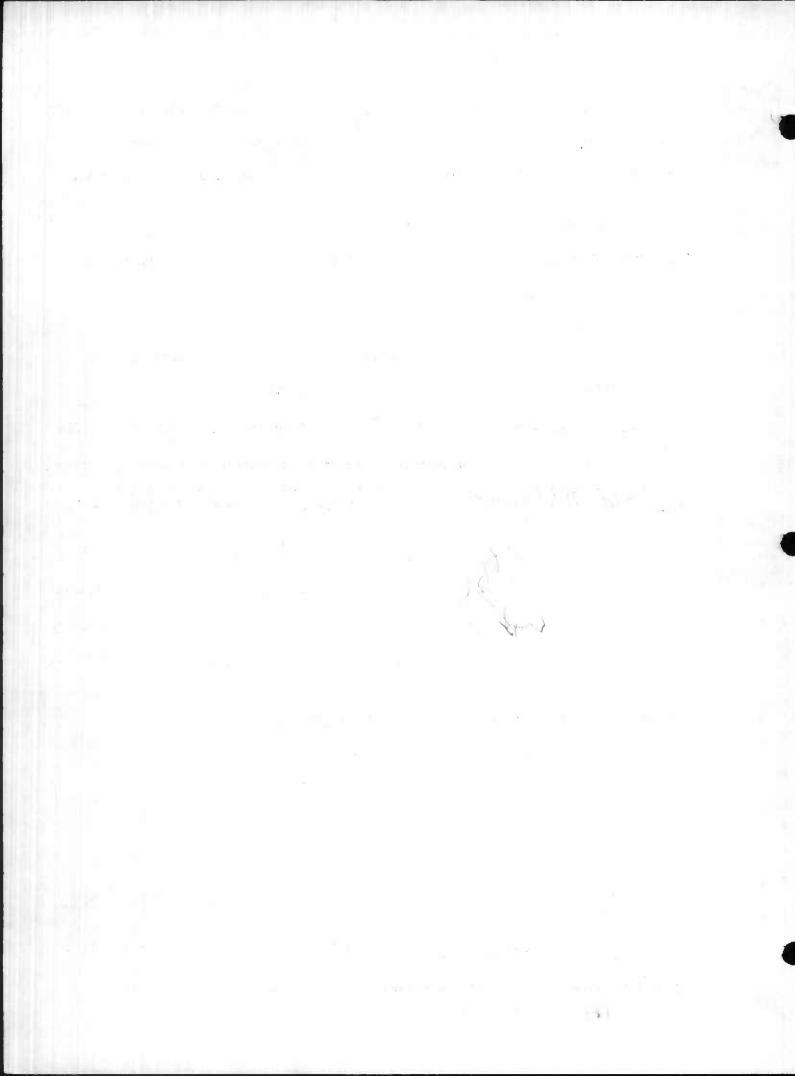


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State of Maryland / Department of Health and Mental Hygiene 98 1 18

					Ce	ertificat	e of	Death		B	eg. No.		1 1		
		Decedent's Nema (First, Middle, Last)				W HEALTH				1				me of Deeth	
Physic		W220 12790			/ 1	Hurley				December		1998	7	7:10PM	
Exami		4a. Fecliity Nema (If not institution, give street and number)			-1				b. City, Town, or Location of Deal			unty of Deeth			
		13047 Penn Shop 5. Social Security Number 6.	est birthday	) If Unda		Mount If Under		/	Frederick						
ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23s or 28s-f show or other traumatic event, the Medical Examine must be notified at the last of the market of th			1□M 2⊠F	Yrs.	Months Devs Ho			Min.	Sept.30				Birthpleca (Stete or Foreign Country) laryland		
		10e. Stete 10b. County		10c. City	, Town or L	ocation		100					10d. Insid	de City Limits	
	Director	Maryland Frederi	ck	Mt	. Air	у							10	Yes 200 No	
		10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?  13047 Penn Shop Road 21771 United States													
	Funeral	11. Marital Stetus	12. Wes Decede	12. Wes Decedent Evar in U,S. Armed Forces?		13. Wes Decedent of Hispanic Origin? (Sp if Yes, specify Cuben, Mexican, Puarto			gin? (Spi	ecify Yes or No-	Race - Amer	ace - American Indian,			
	by Fu	1 ☐ Navar Marriad 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates:			1 ☐ Yas 2 ☑ No Specify:				Hican, etc.)	ecity:	Black, White, etc.			
hou		15. Decedent's E				Sa. Decedent's Usuei Occupation						White Businass/Industry			
ithin 72 e. an "na	Completed	(Specify only highest gri Elementery/Secondary (0-12)	ede complated)	de complated)  College (1-4or 5+)		e kind of wo	kind of work done during most of wo O NOT use retired)		t of work	ing	vi ogonigas				
filed with Hygiene ther the	S		4		]	Nurse					-	sing			
permit. Peges 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, 2006.	Be	17. Fether's Nema (First, Middle, Last	)				18. Mc			Mothar's Name (First, Middle, Melder			en Sumema)		
	2	Woodward O'Hara				Hattie				Scarff					
		19e. Informent's Neme/Reletionship	Type, Print)		19b. Mei	ling Address	S (Stree	t end Numbe	er or Rura	al Route Number	r, City or T	own, Stete, Z	ip Code)		
		Gail Bastian/ Daughter  13047 Penn Shop Road, Mt. Airy, Maryland 21771  20e. Method of Disposition  20b. Place of Disposition (Name of camatery, cremetory or other place)  20c. Location - City or Town, State										7.1 te			
Peges nert of nrt: If ite iry or o		1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		918					amet	ery12/23	Dom	0.0011.0	Mass	v1and	
permit. Departm Importa any inju		21. Signeture of Funarel Service Lice		PIOIT				ass of Facilit		ELY12/4-	Dalli	ascus,	Mary	yrand	
Physician /Medical Examiner		Olin L. Molesworth P. A. Funeral Home													
		26401 Ridge Road, Damacus, Maryland 20872													
		23e. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellura. List only one cause on each lina.													
		Onset end Deeth													
		Immediate Cause (Finel disease or condition resulting in deeth)  e. Colon Corcerona (had resection 9/19/18 north)													
	L	resulting in deelin)		Due to (or	es e conse	equence of):						1			
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and	хап	Sequentially list conditions, if any, leading to immediate  b. adenoratous polyps of color  Due to (or es e consequence of):									1				
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og in	2	history of appropria artery dispasse 1210 418										408			
death ce a attendi d for us	icia	Pert II. Other significant conditions contributing to death but not resulting in the underlying of						cause given in Pert I. 23b.			Did tobacco usa contribute to the cause of death?				
at the by the eleche	hys	Pert II. Other significant conditions contributing to death but not resulting							1 Yee 2 No 3 Probably 4 Unit						
The law requires that the death tite has been signed by the atter page 2 should be deteched for u	by Physician/	glaucoms, Hypertension, car				rolloc arrhythmier				To your Zone of House, we office				V CINAION	
	Completed	including alud fib/flatter, a				nous constipation							opsy findings brior to n of cause		
ne law requires the law requires the law seen signed ge 2 should be contact.	E				. (					400			f death?	•==	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		Hypertophic Co	udwne	50671	aller	810	Ch	W17		1□Y		10 1	☐ Yes	20 No	
	Be	25. We's case referred to medical axaminer?	Hospitel:	0 0			Ott	han		h (Check only or					
	70	1 Yas 2 No	1 ☐ Inp 28a. Dete of I (Month,	atiant 2 E			JA			me 5 Resid			ify)		
	ation	27. Menner of Deeth  1 ☑ Neturel 5 ☐ Pending  2 ☐ Accidant invastigetio	28b. Time Injury					28d. Dascribe h	Dascribe how injury occurred						
	Certification:	3 ☐ Suicida 6 ☐ Could not be determined	me, ferm, s	ferm, street, factory, office 28f.					31. Location (Street end Number or Rural Routa Number, City or Town, State)						
	edicai C	29e. Certifier (Check only   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
the the I	Med	one)													
N N N		29b. Signeture end title of certifier		29c. Licensa number					29d. Deta signed (Month, Dey, Year)						
		marke	XXX	m w			D34	682			December 21, 1998				
		30. Name and address of parson who	completed cause	of beeth (Item	23e) (Type	, Print)									
		Joanne L. Kinney	M.D.	9701 N	ew Ch	urch	Stra	et. D	amac	cus, Ma	rvlan	d 208	72		
St	ate	31. Dete filed (Month, Day Year)		Istrar' Signet		1.		/	C Dilling	- ALC .	-J-EUI	~FVV	, <del>M</del>		
Regist		UEU 2	3 1998	Dene	رمس	Ø.	1	000.16	1						

Registrar



98-7492-021 PHILLIP

HOFE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

101	
	Physician
	/Medical

3. Time of Death 10:30A.M.

1 ☐ Yes ŽQNo

MURPHY

Approximate Interval Between Onset and Death

**Funeral** Director

Directo

þ

Completed

Be

must be notified at "natural", or Itema

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or hem pages.

Baltlmore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physician and s the burial-transit be execu 68760 Physician/Medical Box 980 P.O. Records, by should I Completed certificate Division of Vital Be this Certification: Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Phillip Nelson HOFF DECEMBER 20,1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6114-B MOUNT PHILLIP ROAD FREDERICK FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) April 21, 1950 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months 1 X M 2 □ F 48 Yrs. 217-56-1047 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5756 Sunset View Lane 21703 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Animal Control Officer County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donald. Phillip HOFF Lucille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5756 Sunset View Lane, Frederick, MD 21703 Mary R. Hoff, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Smithsburg Crematory, Dec. 22, 1998 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, M00703 MD 21701 caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, each line. 23a. Part1. Enter the disease, or comptications in shock, or heart feilure. List only one cause of Immediate Cause (Finel Intra-oral disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed? Limited 12 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical exeminer? XXYes 2□ No

27. Menner of Death 5 Pending investigation 1 Natural 2 Accident
3 Suicide
Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Pay Year) Found 98 6 Could not be

28b. Time of Injury untrown 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Woods

28c. Injury at Work? 1 Yes 2/No

Other: 4 Nursing Home 5 Residence 6 DOther (Specify) WOODS 28d. Describe how injury occurred subject shot

26. Place of Death (Check only one)

self 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 [[4 - B M-1, 90:1] Mt. Phillip Frederick County, Manyland

29b. Signeture and title of certifier

29e. Certifier (Check only

> 29c. License number O.C.M.E.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

DECEMBER 21,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

phen adentz 31. Dete filed (Month, Day, Year)

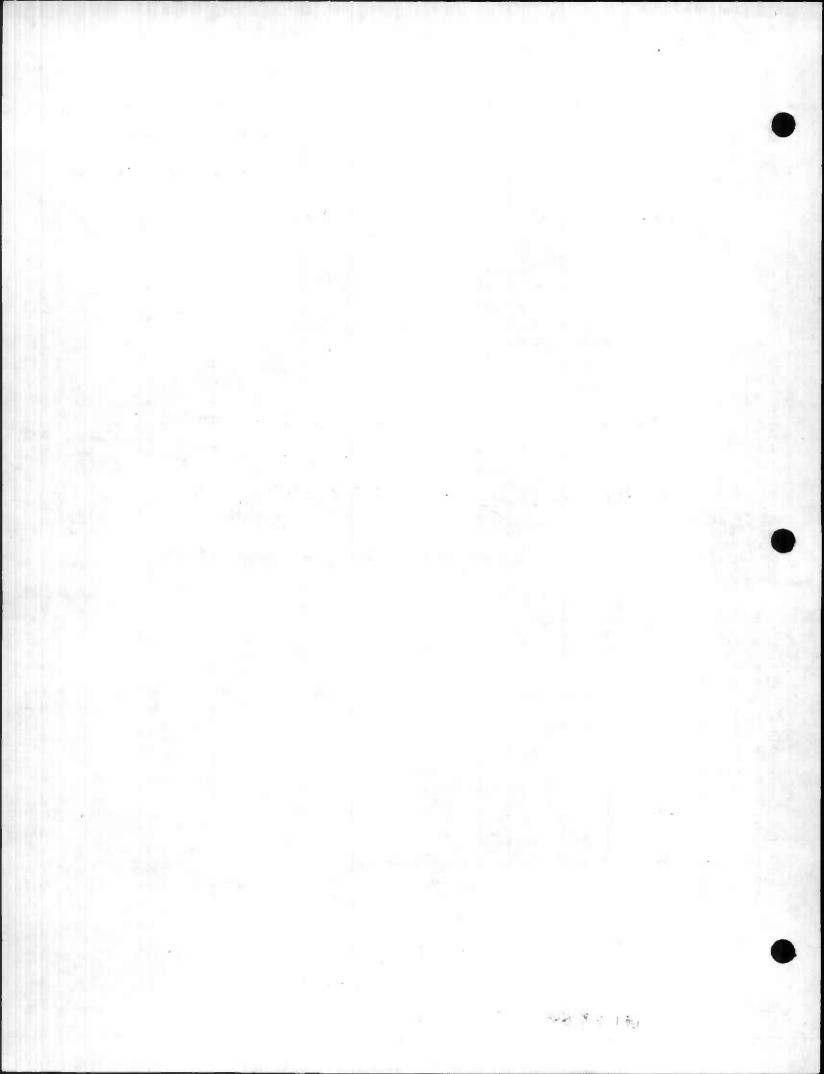
111 Penn Street, Baltimore, Maryland 21201

State Registrar

edical

DEC 2 2 1998

32...Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

**Funeral** Director

the Maryland

Director Funeral þ

Completed

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla. Department of Health and Mental Hydene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an educa-

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

and I-transit physician at s the burial-t signed by the a been si nis certificate has but director, page 2 st this funeral

that the death certificate be executed or Attending Physician: death. blrector: / To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b

Division of Vital Records, P.O. Box 68760,

Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dec. 16, 1998 1:45 PM Anna Margaret Holder 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Frederick Frederick memorial Hospital Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 1916 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days 1 M 2 X F Months Hours 82. Yrs. 220-28-3227 Usual Residence of Decedent 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits Middletown Mi. Frederick 1 Yes 2 No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21769 U.S.A. 14 Locust Blvd. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pharmacy cashier 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Irene Elizabeth Baker Charles Stanley Minnick 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 14 Locust Blvd., Middletown, Md. 21769 Woodrow N. Holder (Husband) 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State Brownsville Hgts. Cenetery 12/20 Brownsville, Md. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signal re of Funeral Ser ice Licenses 22 Nome and Address of Fecility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in deeth) Examine VPERLIPIDEMIA Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest to (or as a consequence of) WPER TENSILL Physician/Medical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? END STAGE RENAL 15√Yes 2□ No 3□ Probably 4□ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed HYPERKALEWIA 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 □ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Sepatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

FREDERICK MD 21702

WILLIAMIT. THUSON

Registrar

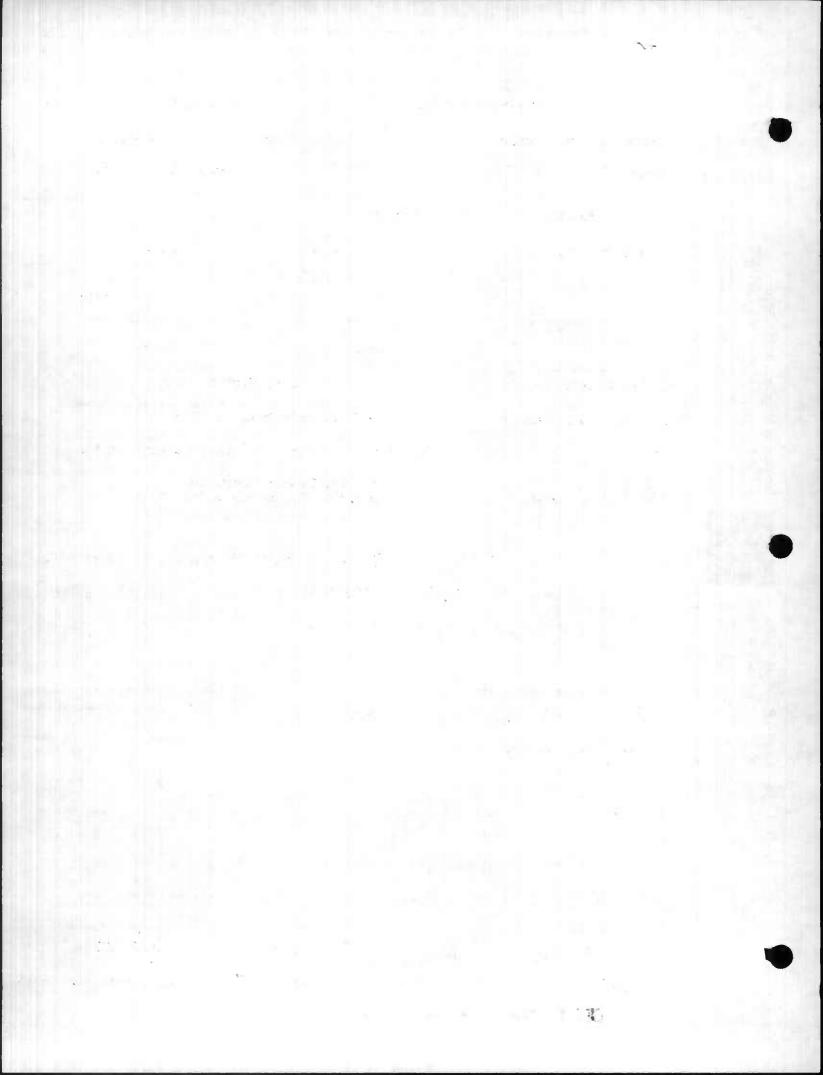
31, Date filed (Month, Day, Year) 32. Registrade Signature DEC 2 3 1998

JUINSON DRIVE

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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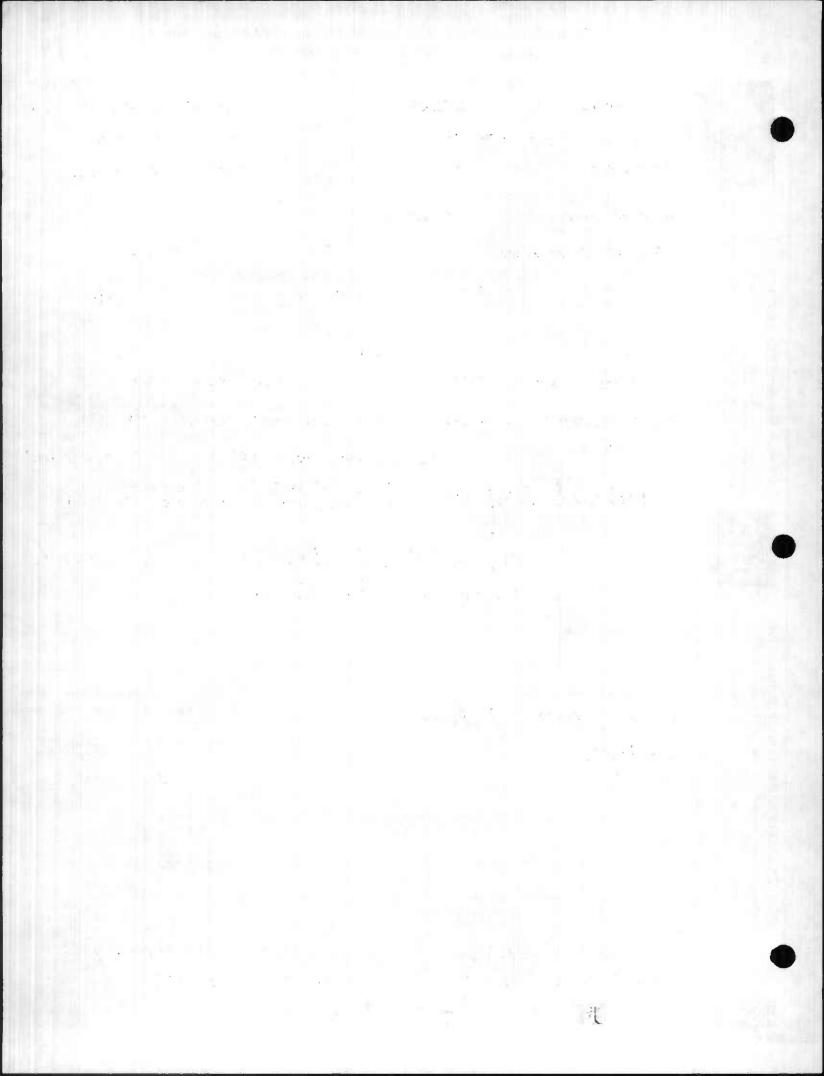
**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene 98 4 4 8 7

						Ce	enilicate	OI .	Death			Reg. No.		
	Physicia /Medic		Decedent's Name (First, Middle BARBARA	ANN		DLLAND					2. Data of Do Month DECEMB	ER 27, 1		3. Time of Death $10:45 \text{ AM}$
	Examin	er	4a Facility Name (If not institution Frederick 1			tal		4	Fre	eder:		Fre	derio	ek
	Funeral Director		5. Social Security Number 212-50-9886	6. Sax 1 ☐ M 2√√√	7. Age (In 49	yrs. lest birthde Yrs.		Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, Di March	16,1949	9. Birthi Coul Mary	piace (State or Foreign nty) /Land
	death with the Maryland ma 23a or 28a-f show must be notified at	ctor	Usual Residence of Decedent  10a. Stata 10b. County  Maryland Frede	erick		c. City, Town or I								10d. Inside City Limits
	h with the	Funeral Director	10e. Street and Number 700 Toll House	se Avenue	2		10f. Zip Co 2	17(	01			10g. Citizan of U.S.A		ntry?
020		þ	11. Marital Status  1 Never Married MM Marri 3 Widowed 4 Divorced	Armed F	2X No	in U,S. 13	. Was Deceden if Yes, specify 1 ☐ Yes 2X			gin? (Spo , Puerto	ecify Yes or N Rican, atc.)		ce - Americk, White,	
21215-0020	be filed within 72 hours after tal Hyglene. d other than "natural", or fre event, the Moorral Exam re	Be Completed	15. Decedent (Specify only highas Elementary/Secondary (0-12)	t greda completed	(1-4or 5+)	(Giv	edent's Usual C re kind of work o DO NOT use i Homemak	dona retire	eation duning mos d)	t of work	ing	16b. Kind of B		dustry
Maryland 2	2 should be filled w and Mental Hygle is marked other the	To Be Co	10 17. Father'a Name (First, Middle, Robert I	last) Mervin	ELLIS		nomemak	er		ra Name	e (First, Middle Mary	, Meiden Surnar	na)	
	P51-4		19a. Informant's Name/Relations! Mrs. Maude Mary		Mothe							per, City or Town		Coda) L701
Baltimore,	ages ent of rt: If it		20a. Method of Disposition  1 Burial 2XX cremation  4 Donation 5 Other (S)			ob. Place of Disposematery, or smithsburg				9, 19	Data 998	20c. Location Smiths		own, Stata , Maryland
Balt	Department Par Important:		21. Signatura of Funeral Service 22. Part 1. Enter the disaase, or shock, or haart failura. List	E. Du	-	255	106 Eas	t (	Church	n St	., Fred	Funeral derick,		21701 Approximate Interval Between
۱	Physician /Medical Examiner		Immediata Causa (Final disease or condition resulting in death)	a. M.	,	1:0	infan	u	tion				1	Onset and Death
68760,	certificate be executed nding physician and use as the bunal-transit	VMedicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or injury that initiated events rasulting in death) Last	b c	Va	an a	equence of):		line	m			1	
, P.O. Box	that the death ed by the atten detached for u	Completed by Physician/	Part II. Other eignificant condition	ne contributing to	death but no	t rasulting in tha	undarlying cau	sa gh	ven in Part I			I tobacco use co	ontribute 1	to the cause of death
ecords	law requires has been sign je 2 should be	pieted b	gentigles	1					1	Ì.	24a. Wa	s an autopsy formed?	av cc	Vere autopsy findings vailable prior to ompletion of cause I death?
ital R		Зе Соп	25. Was case referred to medical						26. Place	of Deat	h (Check only	Yes 2KNo	1	Yes 2 No
Division of Vital Records,	ding Phys h. After this funeral di	sation: To Be	examiner?  1	28a. Date (Mo	Inpatient of Injury oth, Day Yes	2 ER/Outpati 28b. Time Injury		Oth Unjus Woo	4LIN			idence 6 Dot how injury occu		ify)
Divis	- 0	Medical Certification:	3 Suicide 6 Could redetermi	Doll	ding, atc. (S)						City or To	own, Stete)		ral Routa Number,
	To the Hospital o within 24 hours af To the Funeral Di completely filled is	Medica	(Check only 2 Medical I	Physician: To the examiner: On the and ma	e best of my basis of examenar stated.	knowledga, dea mination and/or	investigation, in	my c	pinion, dea	d place, th occur	and due to the red at the time	, date and place	and due	to the cause(s)
	T vitit		29b. Signature and title of certifier	Hopleer	In			)	221	61		29d. Data signa	9/9	, Day, 1881)
			30. Name and addrass of parson Lloyd Halvor					ed	erick	, Ma	ryland	21702		

State Registrar 31. Data filad (Month, Dey, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Day Yaar Olive Hering 26, 1998 4c. County of Deeth December 5:00 P.M. 4e Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick If Undar 24 Hrs. 8 Frederick 8. Data of Birth (Month, Day, Year) June22, 1921 If Under 9. Birthplece (Steta or Foreign Country) Indiana 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F Months Hours 218-24-1299 Usuel Residance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 20 No Frederick Knoxville 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 3658 Petersville Road 21758 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Raca - American Indian, Black, White, etc. 14. Raca -1 Navar Marriad 2 Married 1 Yes 20 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewile Homemaken 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Glenn Tingle Swishen Bessie Catherine Scott 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Son P. O. Box 3 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) Box 310 - Fairfield, PA 17320 Name of Dete 20c. Location - City or Town, Stata Robert T. Hening, Sn. Son 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata

22. Nama and Addrass of Fecility

Hagenstown Crematory 12/28/98 Hagenstown, MD

John T. Williams Fynenal Home Brunswick, MD 27716

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Ite Baltimore, Maryland 21215-0020 th end Mental h

> **Physician** /Medicai **Examiner**

> > pue buriel-trer

the

use

Division of Vital Records, P.O. Box 68760

Department of important: If

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f ahor

Mary

10a. Stata

Director

Funeral

þ

Completed

Be

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funavai Sarvice Licanse

Immediate Ceuse (Finel disaase or condition resulting in deeth)

ρ OL

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last Physician/Medical Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was dash reference examiner?

Completed Be

signed by the

Hospital or Attending Physician: funeral Certification: After 24 hours after death.

Funeral Director: Af To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by th Medical

this

page 2

29b. Signatura and titla of eqrtifiar

1 Yes 2 No

27. Men of Deeth

Naturel

2 Accident

3 Suicida

29e, Certifier

4 ☐ Homicide

28e. Dete of Injury (Month, Dey Year)

Williams,

Owner 23e. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest shock, or heart feiture. List only one cause on each line.

whalerium

Due to (or es e co

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Pieca of injury - At homa, ferm, straet, fectory, offica building, etc. (Specify)

29c. Licansa number

28c. Injury at Work?

1 Yes 2 No

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, date end plece, and due to the cause(s) end menner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

Luderch Wol 21701

23b. Did tobacco use contribute to the cause of death?

24e. Wes en eutopsy

T□Yes 241No

28d. Describe how injury occurred

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

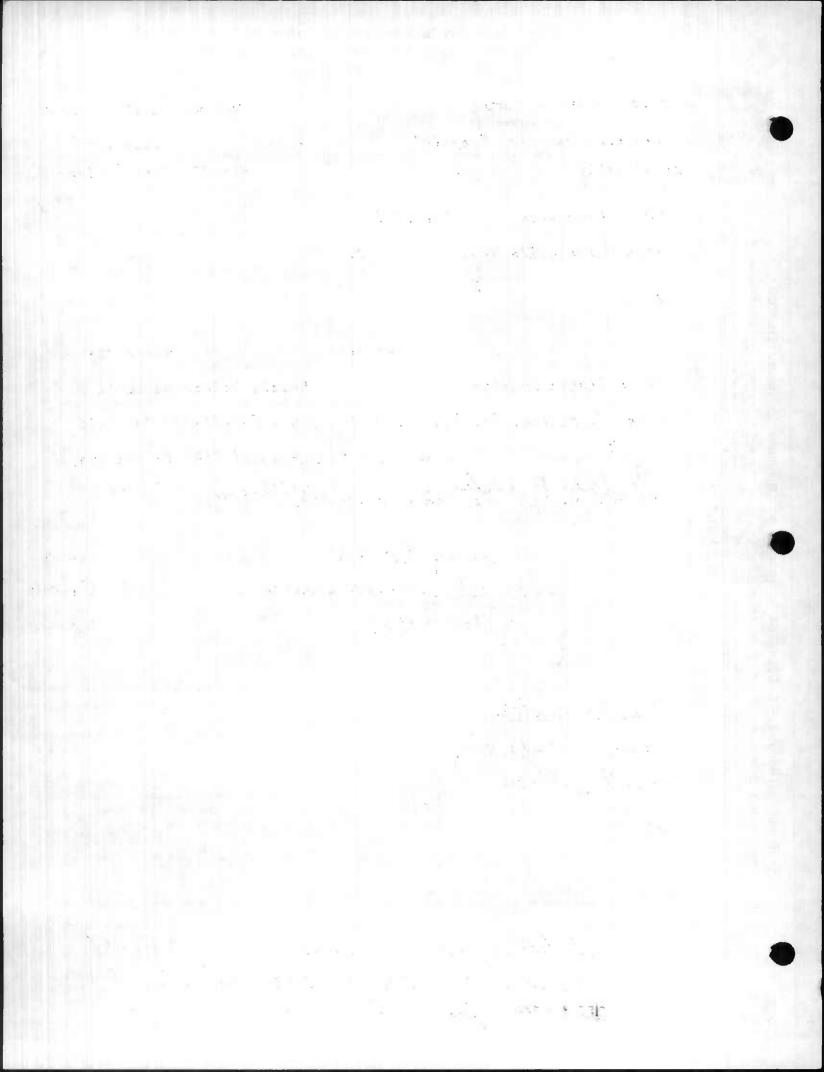
Approximete Intervai Betwean Onsat end Death

th (Item 23e) (Type, Print) 10

Ism

5 Pending investigation

6 Could not ba



Pleas

Pleas			. Assure All Copies A Health and Mental Hygi		1489
		Certificate of	Death Re	g. No.	
1. Decedent's Name (First, Middle,	Last)		2. Date of Death		3. Time of Deeth
CALVIN	Matthew	JAMES	December	Day Year 15,1998	1:40 PM
4a Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of Death	4c. County of Death	

**Physician** /Medical **Examiner** 

4a Facility Name (If not institution, give street and number)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 la marked other than "naturel", or items 23a or 28a-f ahow eny Injury or other traumatic event, the Medical Examiner must be indiffed at once.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

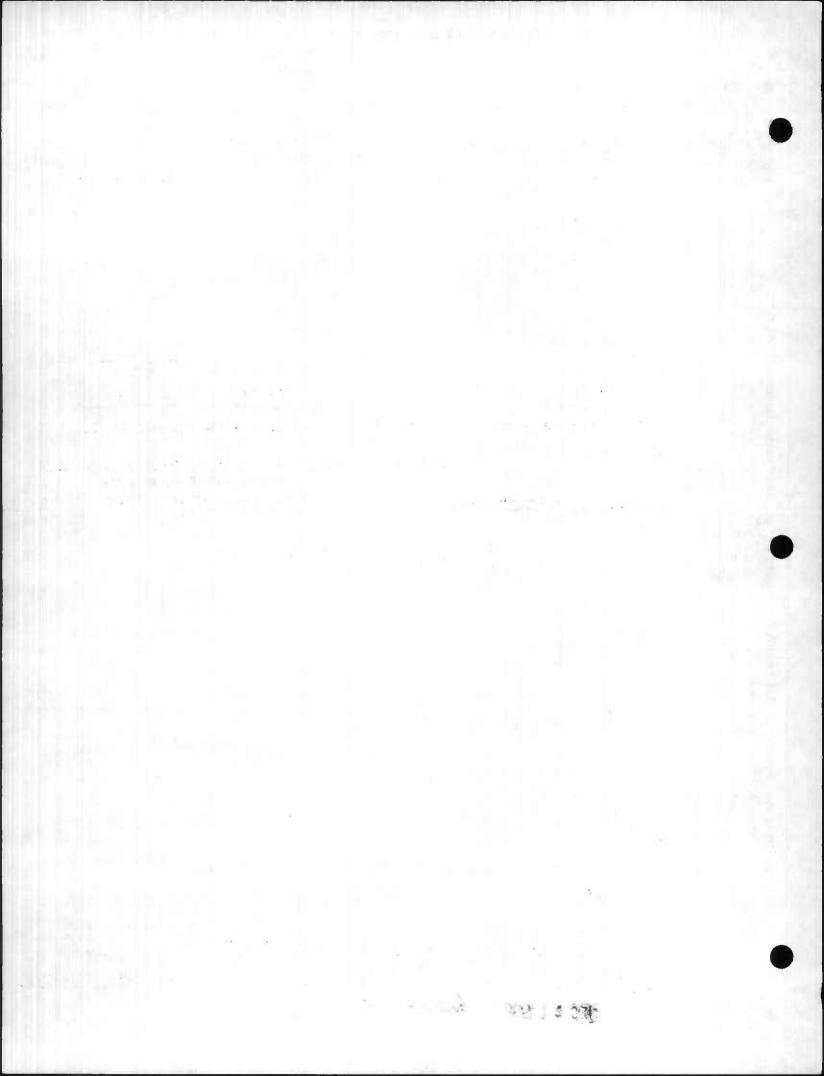
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

College	View H	lealth Ce	nter				Fr	ederi	ck	Free	derick	
5. Social Security Number	6. Se	7. A		ast birthdey)	If Under		If Under Hours	A 1 4 4 T	8. Date of Bir (Month, Da	th	-	e (State or Forei
214-34-1170	11	M 2□ F	60	Yrs.	IAIOHUS	Days	Hours			3, 1938		
Usual Residence of Deced	dent									1_1,50	1 1102	CAAL SA
10a. State 10b. 0	County		10c. City	, Town or Loc	ation						100	. Inside City Limit
Maryland Fr	adoric	l <sub>r</sub>	Frod	lerick								1 N Yes 2 □ N
10e. Street and Number	cuelic	I.	Tred	CIICK	10f. Zip	Code				10g. Citizen o	d Whet Country	7
	477 0											
	AII S	aints St		2 10 140	1	1701		laing (Can)	rif. Vac as Na	United	State	S
11. Marital Status		Armed Forces	?	5. 13. W	Yes, speci	ify Cubar	n, Mexical	n, Puerto F	cify Yes or No Rican, etc.)	В	iack, White, etc	
1 Never Married 2		1 Yes 27		11	☐ Yes 2	No	Specify:			Spec	oify:	
3 ₩ Widowed 4 □ Di		Year or Dates	:								Blac	
	ecedent's Edi highest grad	ucetion de com <i>pleted)</i>		16a. Decede (Give k	ind of worl	k done d	urina mos	t of workin	g	16b. Kind of	Business/Indu	stry
Elementary/Secondary (	(0-12)	College (1-4o	5+)	life. Di	O NOT use	e retired)	,					
10				La	bore	r				Manuf	Eacturi	ng
17. Father'a Name (First, M	Middle, Last)						18. Moth	er's Name	(First, Middle	, Maiden Sum	ame)	
Lew	is	Clavi	n	James			Ma	artha			Rigg	S
19a. Informant's Name/Re	elationship (T	ype, Print)	155	19b. Mailing	Address	(Street a	ind Numb	er or Rura	Route Numb	er, City or Tow	m, State, Zip C	
Justine An	derson	/ siste	r	9545	Keve	Cha	nel I	24 /	Union	Bridge	Md. 2	1701
20a. Method of Disposition		,	20b. PI	ace of Dispos	ition (Nam	10 Of		.u.	Date	20c. Location	n - City or Town	n, State
Burlel 2 □ Crem			0	metery, cremi								
4 □ Donetion 5 □ O			Kes	sthaven	Memo	oria.	1 Cer	n. 12	2-19-98	Frede	rick, Ma	ryland
21. Signature of Funeral S	service Licens			22.	Name and	a Addres	S Of Facili	y Stai	uffer 1	Funeral	Home	
Backers		20/000	mil)	16	21 Or	poss	umtov	vn Pi	ke/ Fr	ederick	, Md.	21702
23a. Part Let the dise shock or heart failur	as , or comp	lications that cause	ed the deeth	. Do not ente	r the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		pproximate iterval Between
or rount rains	o. Elot only c	110 04030 011 04011	1110.		A							nset and Death
Immediate Cause (Finel		No	00.1.	100	MI	1/	11	ati	011			2 mak
disease or condition resulting in death)		a	HOU	race	KI	4	UL	ull	LAVE		- 6	x Well
			Due to (or	as a consequ	ience of):	U					i	
		b										
Sequentially list conditions if any, leeding to immedia	s,		Due to (or	as a consequ	ence of):							
ceuse. Enter Underlying Cause (Disease or Injury		С.										
thet initiated events resulting in death) Last			Due to (or	as a consequ	ence of):							
		d										
		d									1	
Part II. Other significant c	onditions co	ntributing to death	but not resu	iting in the une	derlying ca	ause give	n In Part	l.	23b. Dld	tobacco uas	contributs to t	he cause of deat
10	c 0 / 1	Tol 1	1200 C	1: T.	1				10	Yss 2 No	3 Proba	bly 4 Unkno
NI	LEM	CCI 1.	nece	LLLL	)							
									24e. Was	an autopsy		autopsy finding
									pend	ormed?	compof de	able prior to pletion of ceuse
										/	4	
									10	Yes 2 No	10	res 2 No
25. Was case referred to r examiner?		Marata I				1 -		e of Death	(Check only	one)		
1 ☐ Yes 2 ☐ Ho		Hospital: 1   Inpai	lient 2 🗆 l	ER/Outpatient			4 LYN	ursing Hon	ne 5 Resi	dence 6 🗆	Other (Specify)	
27. Mann Death	Pendine	28a. Date of In		28b. Time of Injury	28	8c. Injury Work	at ?	2	8d. Describe	how Injury occ	curred	
2 Accident	Pending investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	,,	M		res 2□	No				
3 ☐ Sulcide 6 ☐	Could not be determined	28e. Place of I	njury - At ho	me, farm, stre	et, factory,	, office		2			mber or Rural i	Route Number,
4 Homicide		building, e	etc. (Specify	)					City or To	wii, State)		
29a. Certifier 11 C	ertifying Phy	sician: To the bes	t of my know	viedne, death	occurred =	at the tim	e. date er	nd place a	nd due to the	cause(s) and	manner as stel	ed.
		iner: On the basia and manner	of examinati									
29b. Signature and title of	certifier	and manner :	rutou.		290	. 1 icense	number			29d. Date sig	ned (Month, De	v. Year)
No One		1 1			. 1	. 2.001100		20			1 1	0
Milles	XIM	A ('(1)	LULL	J. M	U	0	2C	15 %	7	12	115/4	18

Drederick,

State Registrar

95 31. Date filed (Month,

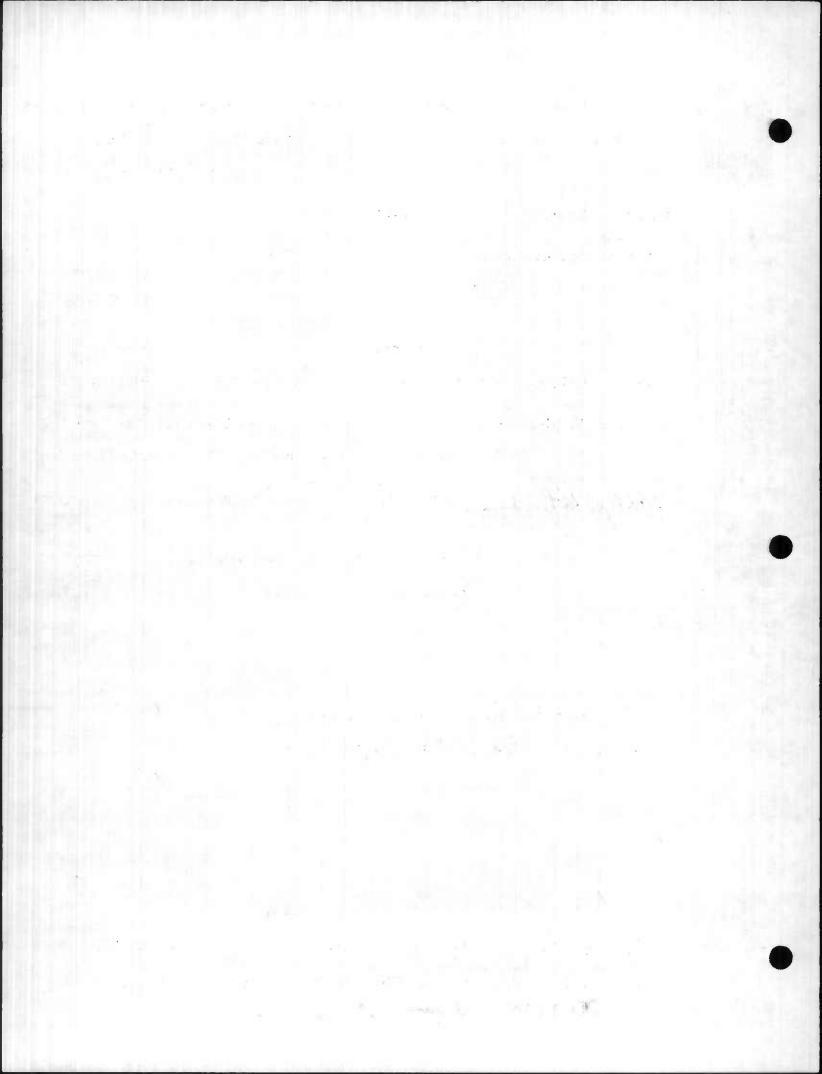


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State of Maryland / Department of Health and Mental Hygiene 9 8

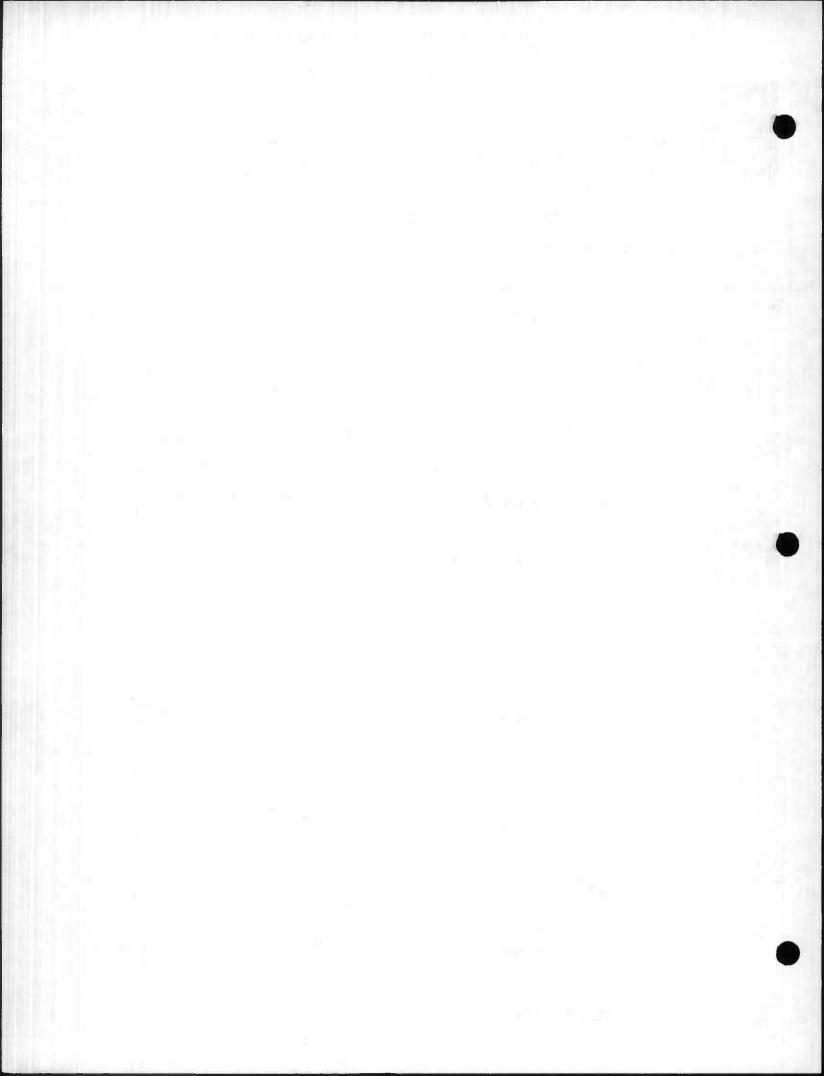
ls	1	l,	9	0

					Ce	rtificate o	f Death		Reg. No.		1750
		1. Decedent's Name (First, Middle,	Last)					2. Date of Dec	Day	Year	3. Time of Death
	Physician /Medical		rly	Jane	9	J0	NES	Decemb	er 28,	1998	11:55 pm
	Examiner	4a Facility Name (If not Institution,						Location of Death			
		Northampton Ma	nor Nursi	ing Cent	er	and the same of th	Frede			ederi	
	Funeral Director	216-14-6971	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. la	st birthday) 74 Yrs.	Months Dey			y, Yeer) 1924	9. Birthp Cour Mary	place (Stete or Foreignty) yland
	2	Usual Residence of Decedent  10a. Stete 10b. County		10c City	Town or Lo	vestion				1	Od. Inside City Limits
	a Maryla be-f eho orfed at	M1 D1	erick		reder						1 X Yes 2 □ No
:	tar death with the Marylan thems 23s or 28s-f show that the routised at the routised at Tuneral Director					10f. Zip Code	21702			J.S.A.	•
020	by by	3X Widowed 4 □ Divorced	12. Wes Dece Armed For 1 Tes If Yes, Give Year or Da		. 13.	Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ N	f Hispanic Origin? ( uban, Mexicen, Pue lo <i>Specify:</i>	Specify Yes or No rto Rican, etc.)		ce - Americ ck, White, y: Wh	etc.
121	within within the same.	15. Decedent's (Specify only highest Elementery/Secondery (0-12)		-4or 5+)	16a. Dece (Give life. Homen	dent's Usuai Occ kind of work do DO NOT use ret naker	cupation ne during most of w ired)	orking	16b. Kind of B	Home	dustry
land	d off	17. Father's Name (First, Middle, L		bert	FOX		18. Mother's No	ame (First, Middle, Credel		ne) ARRIS	ON
ary	E E	19a. informant's Name/Relationshi	ip (Type, Print)		19b. Maili	ng Address (Stre	et end Number or F	Rural Route Numbe	er, City or Town	, Stete, Zip	Code)
	and 2 aalth a n 27 is er tre	Mrs. Betty E. I	Blentling	er/Siste	er 94	128 Gas	House Pil	ce, Frede	rick, N	Maryla	and 21701
nore	agas I ant of He t: if Nen y or oth	20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 4 🗆 Donation 5 🗆 Other (Spe		Cer	metery, crei	sition (Name of metory or other p t Cemete	ery Dec 3	Dete 1, 1998	Freder:		own, State Maryland
Balti	pemit. Pa Departman Important any injury DDCs.	21. Signature of Funeral Service L	0	MOO7	06 1	Of Pant	& Basford	A There are	NA	ome	and 21701
F	Physician	23a. Pa 1. Enter the disease, or c shock, or heart failure. List o	complications that can have one cause on ea	aused the death.	Do not en	er the mode of o	Church S lying, such as cerdi	ac or respiratory a	rrest,	aryra	Approximate Interval Between Onset and Death
	/Medical Examiner	immediate Cause (Final disease or condition resulting in death)	a	15che	m}(	quence of):	ellitur	Argor	)	1	4 years
	<u> </u>			Dink	2021	M	ellitur				Tream
Ć.	axecuted in and faltransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or	es a conse						
x 68760,	erricata be assouted ing physician and as the burial-transit Medical Examir	resulting in death) Last	c	Due to (or a	as a consec	juence of):					
Вох	attendi for use		<u> </u>								
P.0.	tha or tha ached	Part ii. Other significant condition	s contributing to de	ath but not result	ting In the u	anderlying cause	given in Part I.	23b. Dld	1/	3 Pro	o the cause of death bably 4 Unknow
Division of Vital Records,	D 00 000	C.V.A	, De	menti	à ,	Hyper	tension	24a. Was	an autopsy ormed?	av	ere autopsy findings vailable prior to empletion of cause death?
Re	cartificata has rector, page 2							10	Yes 2XNo	10	□Yes 2□No
ta	artifical actor, p						26. Place of D	eath (Check only o		1	
> :	this cartific ral director,	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 E	R/Outpatie	nt 3 DOA	Other I	Home 5□ Resid		her (Specil	(y)
ion o	ath. r: After the funeral			of Injury h, Dey Year)	28b. Time o Injury		ijury at Vork? □ Yes 2 □ No	28d. Describe	how injury occu	rred	
Divis	rs after death.  •I Director: After tied in by the funers  Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zoe. Place	of Injury - At honing, etc. (Specify)	ne, farm, st	reet, factory, offic	<b>28</b>	28f. Location (: City or Tol	Street end Num wn, Stete)	ber or Run	al Route Number,
	To the Hospital or Attending I within 124 hours after death. To the Funerel Director: After completely filled in by the funer Medical Certification:		Physician. To mail xaminer: On the ba and mann	sis of examination	on and/or in	n occurred at the vestigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	date and place	anner as a , and due t	nated. o the cause(s)
1	Within Comp	29b. Signature and title of certifier	λ				ense number		29d. Date signi		
		1 mx	4	Mh		D2	1944		Decembe	r 29,	1998
		30. Name and address of person w James S. Griss					eet, Fred	erick, M	aryland	2170	)1
	21-1-	31. Date filed (Month. Develveer)		egistrar' Slonatu							



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						Cei	rtifica	te of	Death	,	Reg. No.			
	Dhuois	ion	1. Decedent'e Neme (First, Middle, La	st)						2. Data of De	ath Day	Year	3. Tima of	Death
4	Physic /Medi		Gladys Virginia	Joslin						Dec 29		Teal	11:25	am
	Exami		4a. Facility Nama (If not institution, give		7.0				4b. City, Town, or	Location of Death	4c. County	of Death		
			Cuppett-Weeks Nu	rsing Home	2				Oakland	i	Garr	ett		
	Funeral Director		219-46-2014	ex	a (In yrs. last 83	birthday) Yrs.	If Unde Months	or 1 Year Days	If Undar 24 Hr Hours Mir		th y, Year) 1915	9. Birthi Coul Pa	place (Stata o ntry)	x Foreig
	and **		Usual Residance of Decedant  10a. Stata 10b. County		10c. City, To	own or Lo	cation					Т.	10d. inside Ci	its Limits
	Aeryta Paho	0	Md Garret	t		land							1⊠ Yas	•
	the N	Director	10e. Street and Number			Lanc	_	- 0-4-						
	ath with 23a or		706 East Alder S					p Coda 2155	0		10g. Citizen of USA		htry?	
maryland 21213-0020	n 72 hours after death with the Meryland "natural", or frems 23a or 28a-1 ahow adical Examinet must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forcas? 1 ☐ Yes 2 ☑ N If Yas, Giva Yeer or Detes:			Was Dece If Yes, spe 1 □ Yas	ecify Cub	an, Maxican, Pua	Specify Yes or No rto Rican, atc.)		ck, White,		
5	thin 72 ho s. an "natur. Medical	Completed	15. Decedent's Ed (Specify only highast gra		- 10	Ba. Deced	dant's Usu	ual Occup	pation	orkina	16b. Kind of B	usiness/in	dustry	
1	S	uple	Elementary/Secondary (0-12)	Collega (1-4or 5	+)	life. I			during most of wo	Jiking				
1	27 100 100	Con	12	2			Hou	sewi	fe		Homem	aker		
2	0 = 0	Be	17. Fathar'e Nama (First, Middla, Last)						18. Mother's Na	ama (First, Middla,	Maiden Surnar	na)		
2	should be nd Mental marked o	2	John Wilson						Minni	e Paugh				
3	2 she and and list man		19a. Informant's Name/Relationship (1	ype, Print)	- 1	9b. Maliir	ng Addres	s (Street	and Number or F	Rural Route Numbe	er, City or Town	State, Zip	Code)	
	1 and 1 Health em 27 other tr		LeRoy J. Friend			403	Lake	e Av	e. Terr	a Alta,W	Va 2676	4		
	Pages 1 and ment of Health ant: If Item 27 jury or other 1		20a. Method of Disposition		20b. Piaca	of Dispo	sition (Na natory or	me of other pla		Deta	20c. Location		own, Stata	
	Page nt: H		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify											
	255		21. Signature of Funarel Sarvice Licen		1001	Cen	neter	nd Addra	ass of Facility	Dec 31 98	EIK C	arde	n W.Va	
í	Depe impo		11	R		D	avid	Α.	Burdock	Funeral 1	Home			
	_		23a. Pany. Entar tha disaase, or compshock, or haart failura. List only of	) und oak		7	10 C	nurc	h St. K	itzmille	r-Md 2	1538		
			shock, or haart failura. List only	one ceusa on aach iir	tha daeth. D ia.	o not ant	ar the mo	da of dyl	ng, such as cardie	ac or raspiratory ar	rašt,	1	Approximate Intarval Bety	ween
	Physician /Medical Examiner		Immediata Causa (Final diseasa or condition rasulting in death)	a. Pneumo	nia 2-	-		:				 	Onset end E	
	p t	line	_	b								į		
5	icate be executed physician and s the buriel-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D.	Due to (or as	a conseq	uence of)					1		
, 00100,	E 00	Medical	that initiated events resulting in death) Last	d.	Oue to (or as	a conseq	uence of)	:				1		
	ta ett	Physician/								12		-		
	the de	ysic	Part II. Other significant conditions co	entributing to death bu	it not rasulting	In tha ur	nderlying	causa gi	/an in Part i.	23b. Did 1	obacco use co	ntribute to	the cause o	of death
	res that the de signed by the a be deteched (			ASHD						10	Yee 30 No	3□ Pro	bebly 4	Unknow
	Pega P	by										_		
	v requires been sign should be	Completed		Seizure	disor	der				24a. Was perfo	an autopsy med?	av	are eutopsy fi allable prior to	0
	2 S	pide										of	mplation of ci daeth?	ause
	0 - 0	NO.								101	as 20 No	10	☐Yes 2□	No
		Be	25. Was case rafarred to medicai						26. Place of De	eath (Check only o	na)			
	5 00	To	examinar?	Hospital:	nt 2 ER/	Outpatien	t 3 D	OA Oth	nar: 4 Nursing	Home 5 ☐ Rasio	lance 6 DOth	ar (Specif	(v)	
	등 등 등		27. Mannar of Beath	28a. Data of Injur (Month, Day		. Tima of		28c. Inju Wo		28d. Describe				
	Attending r death. ector: After by the fune	atio	14☑Natural 5 ☐ Panding 2 ☐ Accidant Invastigation	(MORIT, Day	Year)	Injury	М		Yes 2 □ No					
	D efte	Certification:	3 Suicida 6 Could not be datarmined	28a. Place of Injubuilding, atc	ry - At homa, (Specify)	farm, stre	eet, factor	y, office		28f. Location (S City or Tox	Street and Numl m, Stata)	per or Run	ıl Routa Numi	ber,
	re Hospital 7 24 hours re Funeral bletely filled	edical (	29a. Cartifier (Check only one) Certifying Phy	reician: To the best of inar: On the basis of and mennar sta	axamination :	ge, daath and/or inv	occurred astigation	at tha ti	ma, data and piac pinlon, daath occ	e, and due to the ourred et tha tima,	cause(s) and madate end placa,	annar as s and due to	tated. the cause(s)	)
	within 2 To the comple	Me	29b. Signature end titla of certifler	/			29	c. Licans	a number		29d. Data signe	d (Month.	Day, Year)	
	->-0		A-11/					Da	1533	5	17/7	7/9		
								100	1		, 0   2	-110	•	
	5		30. Nema and addrass of person who o				,							
	0		Thomas J. Joh	nson, M.D.	, 311	Nort	h Fo	urth	Street,	_Oakland	, MD 2	1550		
	Sta Registr	-	31. Data filed (Month, Day, Year)	32. Ragistra	r's Signatura	, ,	4		· Kal					
	THE PERSON NAMED IN COLUMN 1	47 1 48	1 10 1 2 1	IMME A	-	-	4 .	STATE AND						



**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10e State

Directo

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Examiner must be notified at

the Meryland

with

filed within 72 hours after deeth

Hygiene.

permit. Peges 1 end 2 should be file Department of Health and Mental Hyy Important: If fiem 27 is marked othe any Injury or other traumatic event, bace.

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai

attending physician end for use es the bunal-transit for use es signed by the a peen After this certificate has funeral director, page 2 death. To the Hospital or Attend within 24 hours after death To the Funeral Director: the

by

Completed

Be

Certification: To

edicai

filled in by

completely

The law requires that the deeth certificate be executed

Box 68760,

Records, P.O.

Division of Vital or Attending Physicien: Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieled events resulting in death) Lest Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death?

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient

t Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1/1 Yes 37 No 1 Tes 2 No

1 Yes 2 No 27. Menner of Deeth 5 Pending investigation 1 Watural

28a. Date of Injury (Month, Day Year) 6 Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street end Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

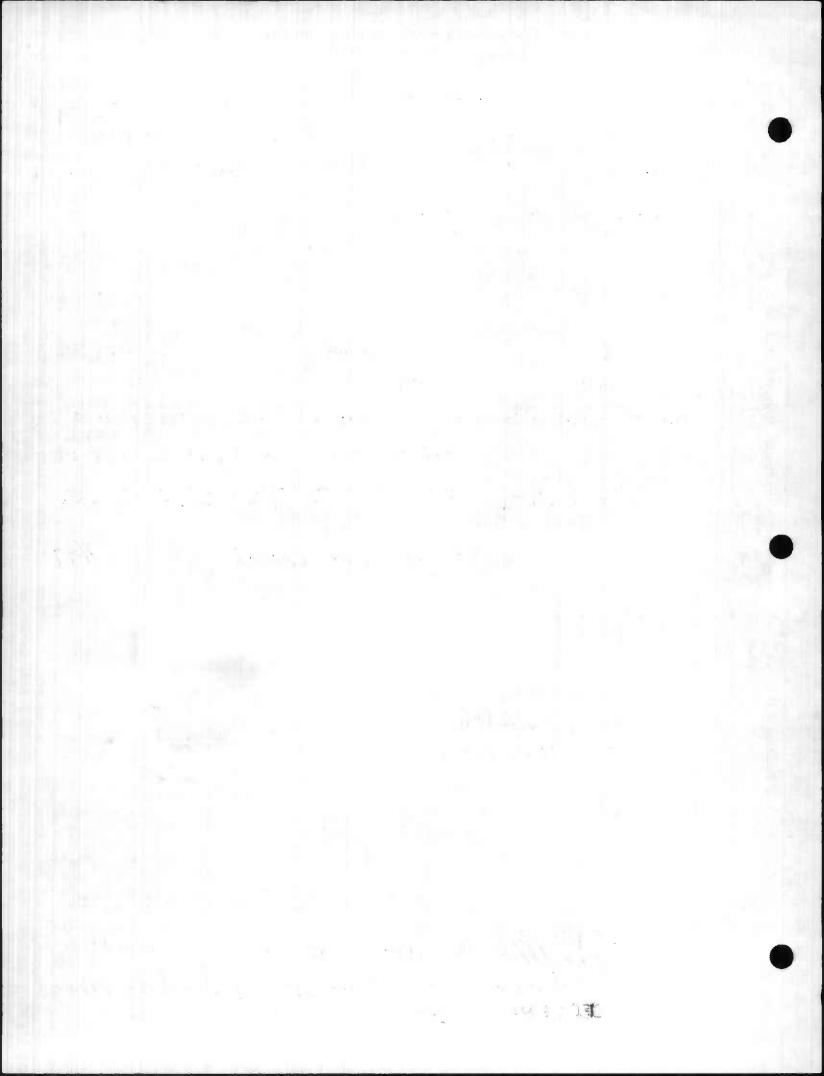
29b. Signature and title of c

7/01

29d. Date signed (Month, Day, Year) December 17, 1998

30. Neme and addre is of r rson wh

federal and 21702 1998 A Signeture CL 31. Dete filed Month



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death December 26, 1998 6:16 P.M. 4c. County of Death 4b. City, Town, or Location of Death Frederick Frederick # Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. March 29, 1922 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) M 2□ F 76 Yrs. 10d. Inside City Limits

1. Decedent's Name (First, Middle, Last) **Physician** Frederick George Kelly /Medical 4e Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital **Funeral** 072-14-1101 Director Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location 10h Count pernit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinet must be not find at once. Frederick Frederick Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 2463 Five Shillings Road Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 1 Never Married XX Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Federal Government Social Worker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) KELLY Roberty 19e. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2463 Five Shillings Rd., Frederick, MD 21701 Mrs. Ardrey J. Kelly, wife 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory, December 30, 1998 Smithsburg, Maryland 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service License and ( MO0255 106 East Church St., Frederick, MD 23a. Pert1. Enter the disease, or complication, that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical H TheroscienTIC CAMPIONASCULAR DISEACE Examiner Due to (or as a consequence of): Examiner the deeth certificata be executed attending physician and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hody Kins Lymphoms

has cartificate ha

þ

edicai

25. Was case referred to medical

1 Yes PE No

27. Menner of Death

1- Naturel

2 Ancident

3 ☐ Sulcide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Dey, Year)

Completed Be Physician: 2 this Certification: Aftert or Attending death. 6 after 24 hours after Funeral Directletaly filled in b

> State Registrar

29b. Signature and title of certifier MO

5 Pending Investigation

6 Could not be

29c. License number D0035152

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

29d. Dete signed (Month, Day, Year) 12.28.98

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

XX Yes 2 No

Black, White, etc.

MCCLUSKY

21701

Approximata Interval Between Onset and Death

VEAN

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . L. KRANTZ,

180 Thus. Tohusan Drive,

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Data of Injury (Month, Dey Year)

Frederick MD

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

24e. Was an autopsy performed?

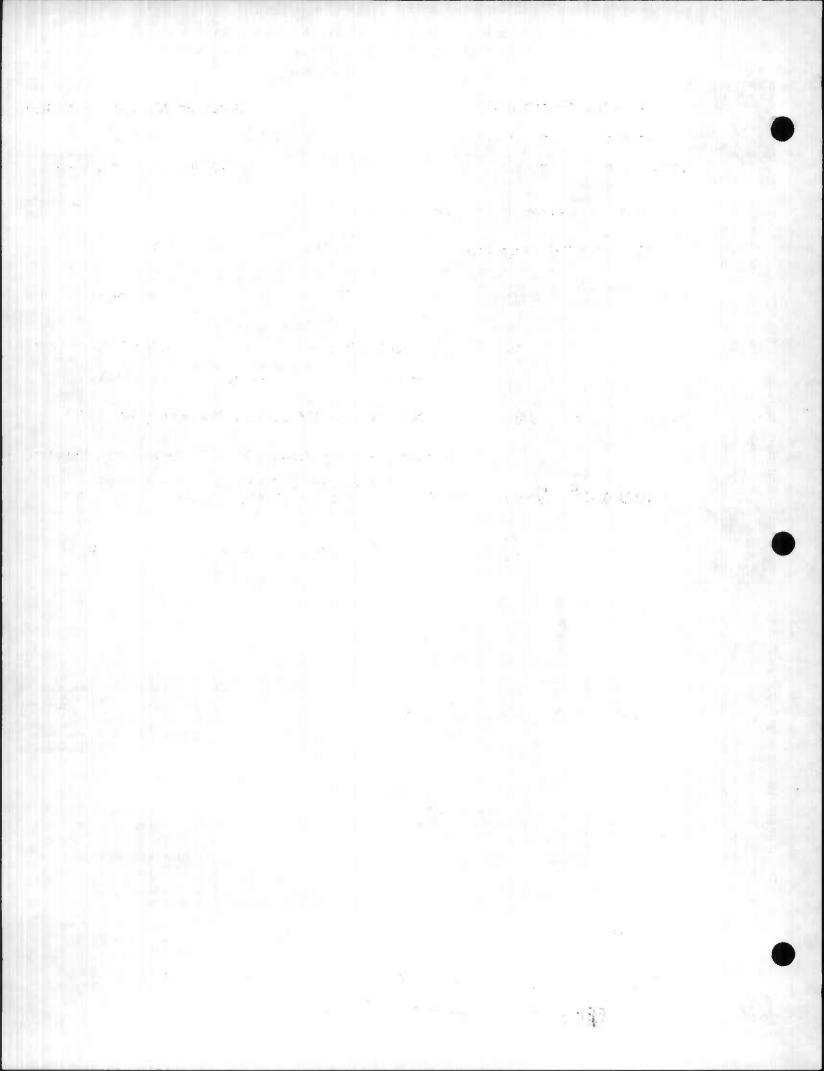
1 Yes 2 No

28d. Describe how injury occurred

32. Registrens Signature

Hospital

To the Hosp within 24 hos To the Fune completaly fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical	Decedent'a Neme (First, Middle, Last)     Mamie
Examiner	4a Facility Neme (If not Institution, give s Northampton Mar

LOWEDV

2. Date of Deeth December Day 1 085 3. Tima of Death 8.15 AM

**Funeral** 

Director

with the Maryland pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumstic event, the Marical Experies must be notified anone.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760, the signed by ti has within 24 hours after death.

To the Funeral Director: After this certificate the completaly filled in by the funeral director, pag

al	Mainte	Trelle		TOMET	۱,		D	ecember	24, 1	1990 0	. I J But
er	4a Facility Neme (If not Institution, give Northampton Ma		ng Home			4b. City, To Frede	wn, or Locat erick	ion of Death	4c. County Frede		
	214-62-3376	Sex I□M 2XXF 7. Ag	e (In yrs. lest bir 92	Yrs. If Un Monti	der 1 Yeer hs Deys	If Under Houra	24 Hrs. 8. Min. No	Dete of Birth (Month, Day, Y	1906	9. Birthplace Country) VIIG	(State or Foreign
tor	Usuel Residence of Decedent  10a. Stele  10b. County  Maryland Freder	rick	10c. City, Tow	n or Location Frede	erick						Inside City Limits
i Direc	10a. Street and Number 200 East 16th St	treet		10f.	Zip Code	21701		100	. Citizen of V	Whet Country? U.S.A.	
Be Completed by Funeral Director	11. Maritel Status  1 Never Merried 2 Merried  3 X Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1  Yes 2  H Yes, Give Yeer or Detes:		If Yes, s	cedent of pecify Cub	an, Mexicar	igin? (Specify n, Puerto Ric	/ Yes or No- an, etc.)		e - American lock, White, etc.	
Completed	15. Decedant's E (Specify only highest green Elementery/Secondery (0-12)			Decedent's U (Give kind of life. DO NO Homema	work done T use retire	during mos	t of working	16		own Hom	
Be	17. Fether's Neme (First, Middle, Last,	)						irst, Middle, Me		10)	
40	Giles R. Corell	7	401	Barbin Add	(Ct	_		A. Feat		State Zin Co.	da)
	Joyce K. Horton,			_				oute Number, ( essup,			10)
	20e. Method of Disposition  1 Burial 2 Cremetion 3 C  4 Desetion 5 Other (Specific	Removel from State	20b. Piece o cemete	f Disposition (	Neme of or other pla	108)			c. Location -	City or Town,	
	21. Signeture of Funerei Service Licer	Basfork	M00021	Keene 106 I	ey an East	Church	ford P	.A. Fun	ick, N		1
	23e. Pert1. Enter the disease, or com shock, or heert feilure. List only	one cause on each li	tha deeth. Do	not enter the n	node of dy	Ing, such as	cardiac or re	espiretory erres	it,	Ap	proximate erval Between set end Deeth
	Immediate Ceuse (Finel disease or condition resulting in deeth)	θ	Acute R	enal Fa	ailur	е				1	Week
iner		h	Dua to (or as a	consaquence	of):						
Ехаш	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Causa (Disease or injury		Dua to (or es e	consequence	of):						
Medica	thet initieted events resulting in deeth) Last	d.	Due to (or es e	consequence	of):						
Physician/Medical Examiner	Pert II. Other eignificant conditions of Obstructive Jan		ut not rasulting i	n the underlylr	ng causa g	van in Part	l				cause of death
Completed by	Dementia					V		24e. Wes en performe		availat	autopsy findings ble prior to etion of cause th?
Сотр	Coagulopathy							1 🗆 Yes	2XNo		es 2 No
Be	25. Was case referred to medical examiner?	Hospital:				han -		Check only one			
T0	1 Yes 2 No	1 L Inpatie			DOA			5 Residen			
ation	27. Menner of Death  1 Naturel 5 Pending 2 Accident invastigation			Time of injury M	28c. Inju Wo	ry at ork? ] Yes 2 □		I. Describe how	r injury occur	190	
Certification:	3 Sulcide 6 Could not b 4 Homicide determined	28e. Plece of inj building, etc	ury - At home, fe c. (Specify)	erm, street, fed	etory, office		28f	Location (Stre City or Town,	eet end Numt State)	ber or Rurel Ro	ute Number,
-											

Medical

Richard Gough MD State Registrar

30. Neme and eddress

29b. Signature and title of certified

29a. Certifier (Check only one)

1X Certifying Physician: 2☐ Medical Examiner: O

32. Registre's Signeture

cause of deeth (Item 23e) (Type, Print)

19 West Frederick Street, P.O. Box 328, Walkersville, MD 21793

29c. License number

D 32171

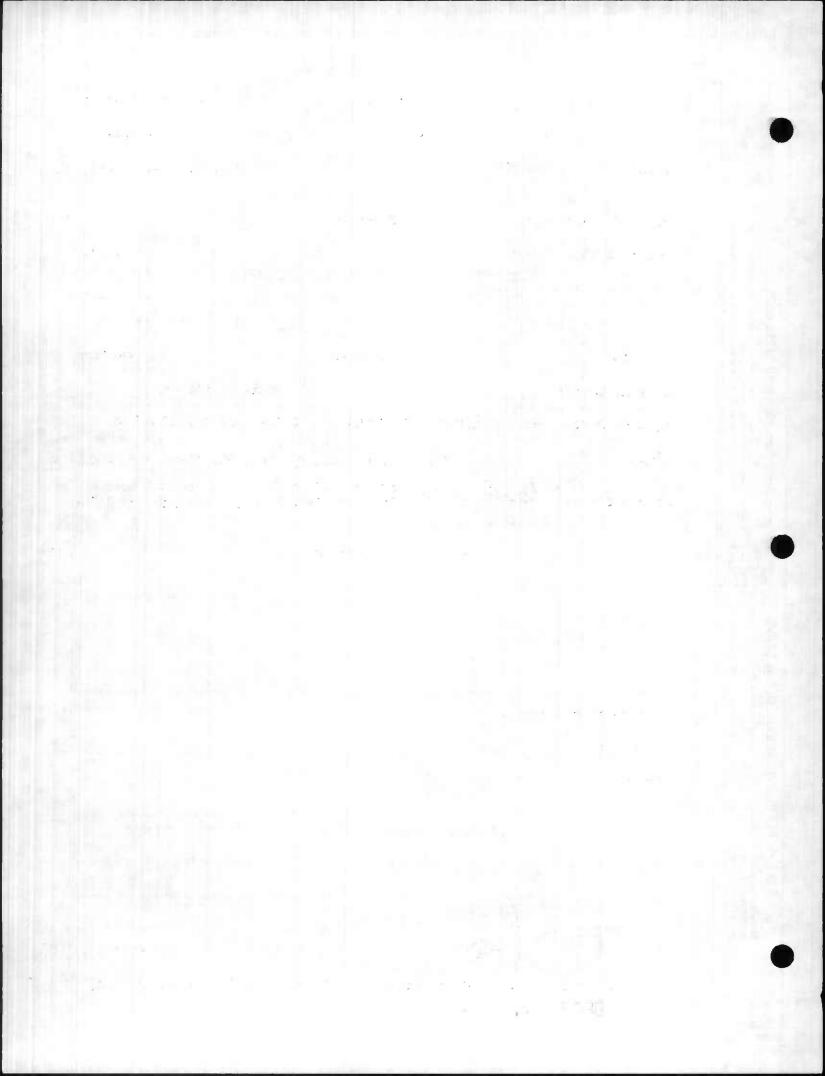
the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

29d. Date signed (Month, Day, Year)

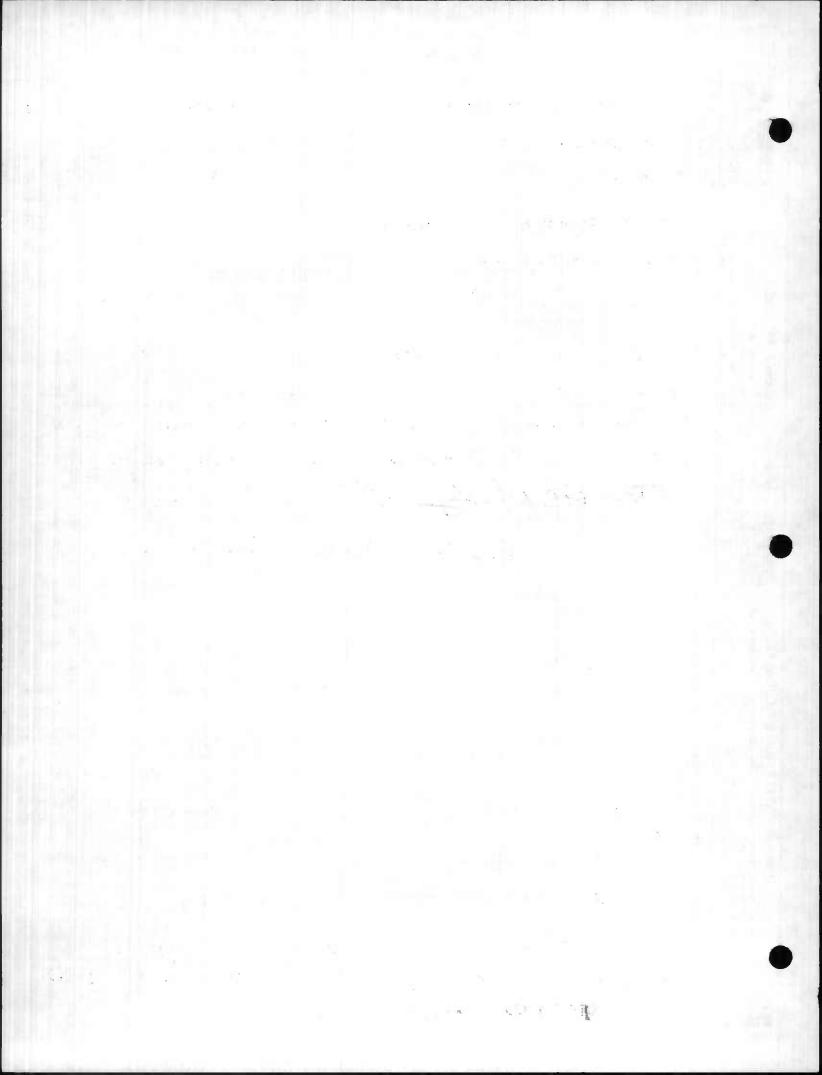
December 24, 1998

**DHMH 16 Rev 6/95** 



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State	of Maryland / De	partment of I ertificate of		ental Hygie		1495
		Decedent's Neme (First, Middle, Last)				2. Dete of Deeth		3. Tima of Death
П	Physician	JEAN ELIZABETH FERGI	JSON LADINO		T) I	Month ECEMBER	Day Year 22, 1998	10:50 AM
1	/Medical Examiner	4a Facility Name (If not institution, giva street and r			4b. City, Town, or Loc		4c. County of Deal	
4	Z.Adiiiiiici	8207 Edgewood Church Ro	oad		Frederick		Frederic	k
	Funeral	5. Sociel Security Number 8. Sax	7. Aga (In yrs. lest birthda	Months Deys		8. Date of Birth (Month, Day, Ya		thplace (Stete or Foreign buntry)
п	Director	212-50-7916 1□M 2\(\overline{\text{Y}}\)F	78 Yrs.	Months	Vious Will.	Sept 1,	1920 EN	GLAND
	p .	Usuei Residence of Decedent  10e. Stete 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	sho sho							1 ☐ Yes 2 ☑ No
	vith the Ma	Maryland Frederick  10e. Street and Number	Frederi	.C.K. 10f. Zip Code		100	. Citizen of What Co	
	with with							
	urs after death v	8207 Edgewood Church Ro		21702 3. Was Dacedent of	Hispanic Origin? (Spec		United St	
	Her d	Armed	Forcas?		Hispanic Origin? (Spec ben, Mexicen, Puerto R	lican, atc.)	Black, Whit	
020	urs a	3 ☑ Widowed 4 □ Divorced Yaar or	ive -	1□ Yes 2ŪNo	Specify:		Specify: W	hite
21215-0020	be filed within 72 hours after death with the Maryland Ial Hyglene. I other than "natural", or items 23s or 28s-f show event, in a Medical Engine must be notified at Be Completed by Funeral Director	15. Decedent's Education		cedent's Usuel Occu	pation during most of working	161	b. Kind of Business	Industry
21	en "n	(Specify only highest grade completed Elamantary/Secondary (0-12) Collega	(1-4or 5+)	e. DO NOT use retire	ed)			
	other than vent, tre M	10	- Hom	emaker			self	
pu	0 = 0 = =	17. Fether's Neme (First, Middle, Last)			18. Mother's Nama	(First, Middla, Mei	iden Sumame)	
yla	should be nd Mental marked o umatic sve	Dr. John Ferguson			Olive Ber			
Maryland	le short la marand	19e, Informent's Name/Reletionship (Type, Print)			ot end Number or Rural			
	1 and 1ealth im 27 ther tu	Tess Davis / daughter		Edgewood sposition (Name of	Church Ro		erick, MD c. Location - City or	
JOL	Pages nent of h int: If its iry or of	1 ⊠ Buriai 2 ☐ Cremetion 3 ☐ Removel from	n Stete cematery, o	cremetory or other pla				
Baltimore,	rtmer rtant:	4 Donetion 5 Other (Specify)	Resthav	en Mem Ga		2/26/9B I	Frederick	, Maryland
Ba	permit. Pages 1 and 2 should Department of Health and Mer Important: if item 27 is marke important: or other traumatic once.	21. Signeture of Funerel Service Licensee	1/- 8	22. Nema and Addr tauffer F	uneral Home	es, P.A.		
_		1-5.Me			umtown Pik			21702
		23a. Pert1. Enter the diseese, or complications the shock, or heart failure. List only one cause or	eech line.	enter the mode of dy	lng, such es cardiac or	respiretory errest	,	Approximata Interval Between Onsat end Deeth
1	Physician /Medical	Immediate Cause (Final	0 Ctan	1801	enic He	. to.		
	Examiner	disease or condition resulting in deeth) e.			enic 10-	an Di	reary	orthono
	i i		Due to (or es a con	sequence of):				
	executed in and ial-trensit	Sequentially list appointing	Due to (or es a con	sequence of):				
ó	te be executed ysiclan and ne burial-trensit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	00010 (0100000)	554551155 517.				
68760,	nysicia he bur	thet initiated avents	Due to (or es e cons	sequence of):				
39	requires that the death certificate be executed seen signed by the attending physician and should be deteched for use as the bunal-trensit eted by Physician/Medical Examir	rasulting in death) Last						
Box	to the death certificate by the attending place as the steched for use as the physician/Med	d						
0	the a hed f	Pert II. Other significant conditions contributing to	death but not resulting in the	e underlying ceuse g	iven in Pert I.	23b. Dld toba	cco une contribute	to the cause of death?
<u>o</u> .	d by detect					1 Yes	2□ No 3□ P	robebly 4 Unknown
18,	signed d be d					04. 100.	1 24h	Mara autopou findings
0	been si should leted					24a. Wes an a performa	d?	Were autopsy findings available prior to completion of cause
Records,	2 2 S						10	of death?
8	cate					1 Vec	20XN6	1 ☐ Yes 2 ☐ No
Vital	Physician: The law rthis certificate hes brail director, page 2 s	25. Was case referred to medical examiner?  Hospital:		10	26. Place of Death			
of	Physic of ral direction To To To To To To To To To To To To To	TE Tes ZZENO	Inpatient 2 ER/Outpa e of Injury 28b. Time	tient 3L DOA	- Unuising Hon	ne 5 K Residence 8d. Describe how	be 6 Other (Spe	ecify)
no	After fune	1 Neturel 5 □ Pending (Mc	onth, Dey Year) Injur	y We	ork?	ou. Describe now	injury occurred	
2	Attending or death. ector: After tune by the fune iffication	3 Suicide 8 Could not be 200 Blo	ce of Injury - At homa, farm,			8f. Location (Stree	et end Number or R	ural Route Number.
Division of		4 Homicide determined 266. Pie	ding, etc. (Specify)	ondar, ractory, omoc		City or Town, S		
	To the Hospital or within 24 hours after To the Funeral Direction pletely filled in Medical Cert	29a. Certifier 1 Certifying Physician: To ti	ne best of my knowledge, de	eath occurred et the t	time, dete end plece, a	nd due to the ceus	se(s) and manner s	s staled.
	n 24 hound n 24 hound he Funer pletsky fill	(Uneck only 21 Madical Examiner: On the	besis of examination end/or inner steted.	investigetion, in my	opinion, deeth occurre	d et the time, dete	end place, and du	e to the cause(s)
	To the within To the comp	29b. Signatura and titla of certifier		29c. Licer	nsa number	29d	. Dete signed (Mon	th, Day, Year)
		I am Alt	- Mh	D.	21944	1	2/22/19	?
		30. Name end eddress of person who completed ca	use of deeth (Item 23e) (Typ	pe, Print)	CT L	- 0		21201
		Jones S. Grissen	my 301	o w yth	57.	redem	M. Md	21701
	State	31. Dete filed (Month, Day, Year) 32.	Registrar's Signeture	4	1			
	Registrar	PEO E 9 1350	7 -	1. P	porks			



physicien end the buriel-trans physicien signed by t Division of Vital this After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the function.

**Physician** 

/Medical

Examiner

**Funeral** 

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items 23a or 28a-f ahow iner must be notified at

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Funeral

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death

permit. Pages 1 and 2 should be filed within 72 hours eiter to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "patural", or hen any injury or other traumatic event

**Physician** 

/Medical

Examiner

Examiner

Physician/Medical

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Certification:

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29e. Certifier (Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0020

State Registrar

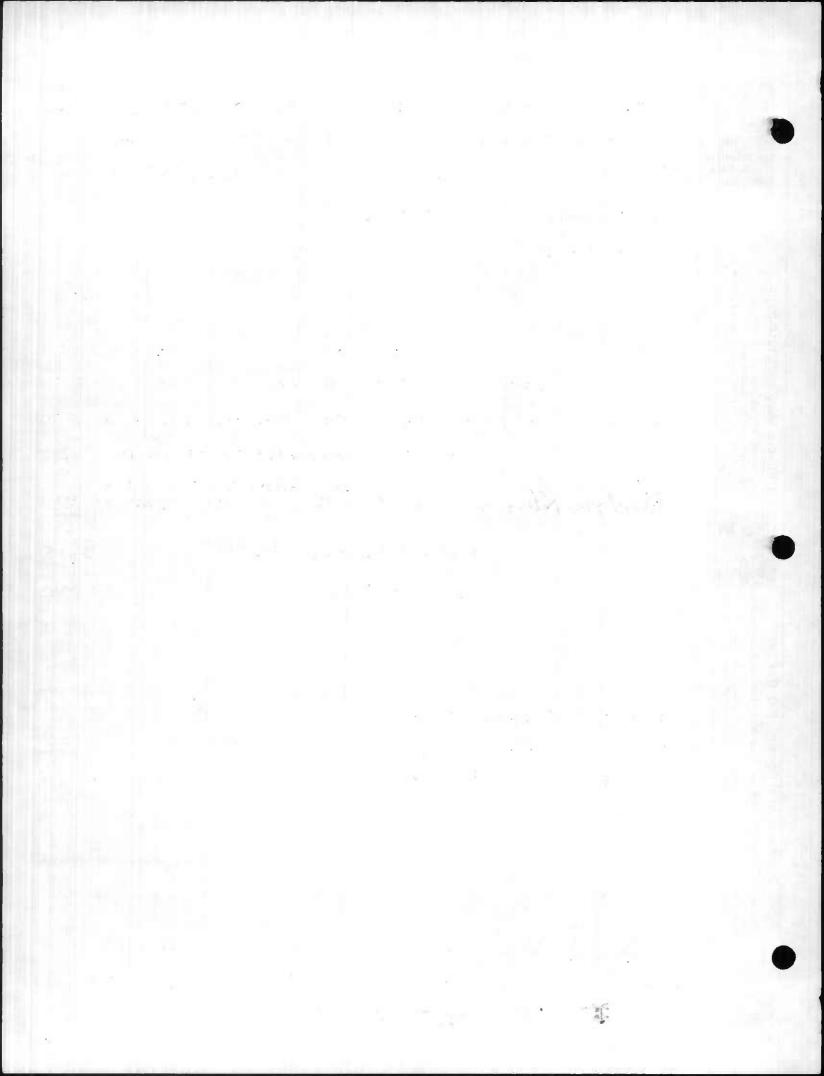
29c. License number mil

TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of death (item 23a) (Type, Print) Jan

Frederick Grisson Mis 300 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture



**Physician** /Medical **Examiner** 

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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Records, P.O. Box 68760

Division of Vital

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Medical Certification:

**Physician** 

/Medical

**Examiner** 

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MD

**Funeral** 

Director

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itam 27 is marked other than "naturel", or items 23a or other traumstic event, the Medical Examinar must be a

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentai Hygiene. Important: If item 27 is merked other than "naturel", or item eny Injury or other traumetic axant

Baltimore, Maryland 21215-0020

Director

Funeral

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death with

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Wes cese referred to medical examiner? 1 ☐ Yes 2 No Inpatient 2 ER/Outpetient 3 DOA

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

27. Menner of Deeth 2 ☐ Accident

3 Suicide

4 Homicide

28a. Dete of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifler

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as steted.
2 Medical Examinar: On the best of exemination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and dua to the ceuse(s) and menner stated.

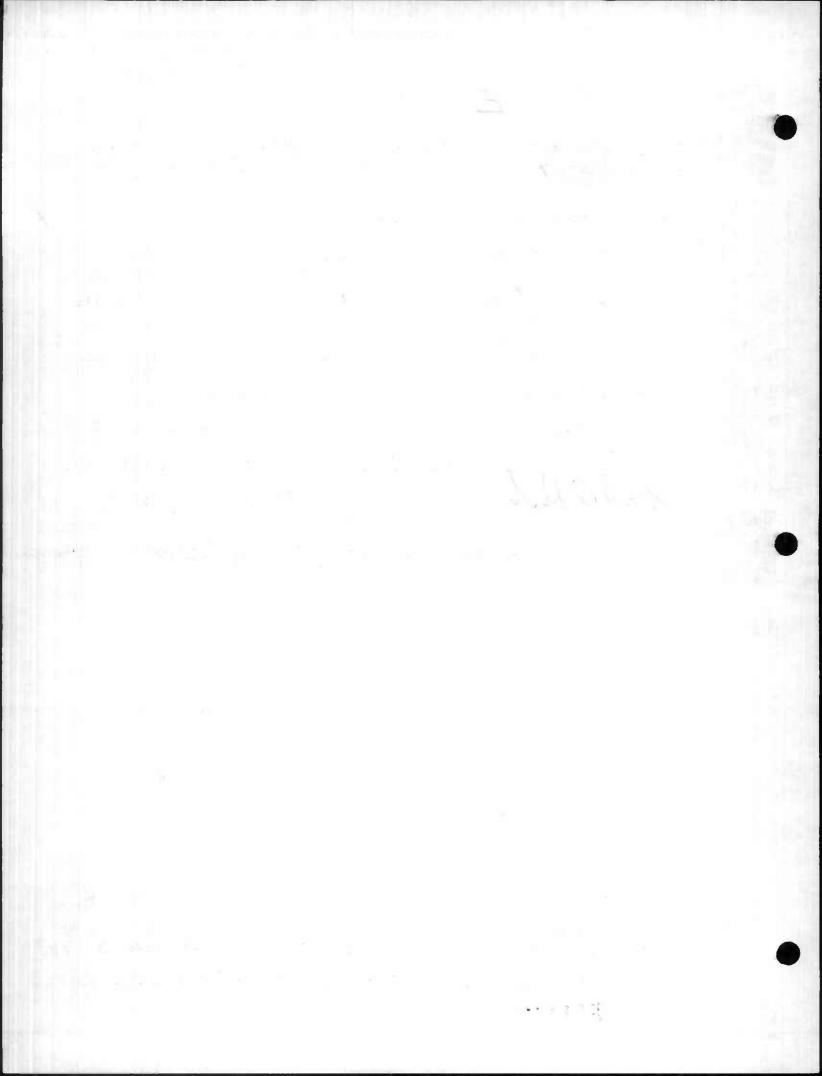
29b. Signeture and title of certifies

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GROVE RD ROCKVILLE MD 20250 CHANALES 15245 SITADY 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Vear Donald L. Lowe, December 29, 1998 3:43 AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner ROCKVILLE

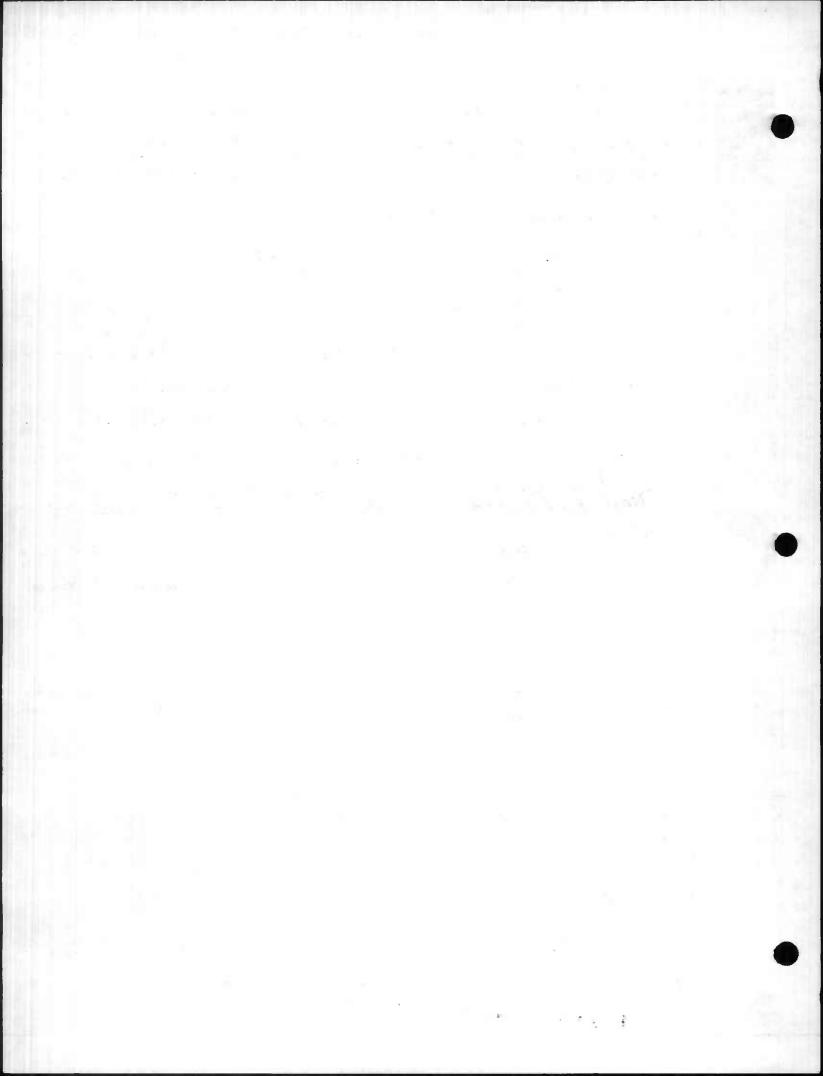
If Under 24 Hrs.

So. Date of Birth
(Month, Day, Year)

Tan. 24, 1928 Shady Grove Adventist Hospital Montgomery 5. Sociel Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 101M 2□ F Months Days Maryland Director 212-24-4550 Usuel Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ehow r than "natural", or items 23a or 28a-f ehor the Medical Examiner must be notified at Maryland Montgomery Damascus 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 24524 Ridge Road 20872 U.S.A. Funeral daath 12. Was Decedent Ever in U,S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Detes: WWII 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien, Black, White, etc. 72 hours aftar 1 ☐ Never Merried 2 ☒ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 Is merked other than any Injury or other traumate. Heating & Elementery/Secondary (0-12) College (1-4or 5+) Contractor Air Conditioning 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Ernest Lowe Lillian Earp 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donald L. Lowe, Jr. - Son 90 Waverly Drive - F101 Frederick, Maryland 21702 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 12/31/98 Gaithersburg, Maryland Other (Specify) Forest Oak Cemetery 21. Signature of Funera Servica Licansee 22. Name end Address of Fecility Olin L. Molesworth P.A., Funeral Home 23a. Pert1/Euer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory shock, others feiture. List only one cause on each line. Damascus, Maryland 20872-011 Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final ARRYTHMIA 1/2 HOUR VENTRIGUM disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): WARG6 CELL, INTERMEDIATE GRADE MONTHS LYMPHOMA bunial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 88 for use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown MRIM FIBRILLATION Records, by 24a. Was en eutopsy performed? 24b. Were eutopsy findings availeble prior to completion of cause of death? Completed peen 1 ☐ Yes 2 No this cartificata 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 28. Plece of Deeth (Check only one) Hospitai: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) Hospital or Attending PI
 24 hours after death.
 Funeral Director: After the letely filled in by the funeral 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how Injury occurred Division 5 Pending Investigation 1 Naturei 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide To the Hospital c within 24 hours a' To the Funeral C completely filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) MARYLAND D42452 29 \* DAY OF DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. CHITTA RAJA GOPPL, M.D SUITE 327. PHILIP PRINCE DRIVE OLNEY, MD 20832 31. Dete filed (Month, Dey, Year) 32. Degistrar's Signeture State Registrar DEC 3 n 1998

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

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								ertificat					Reg. No.			
Physicia /Medica		1. Decedent's Nar	WERNO		EIGHTON							2. Dete of De Month DECEMB	Day	1998		:00 AM
Examine		4a Facility Name 310 W	(If not institute			ber)			4	b. City, To		ocation of Deat		nty of Deeth		
uneral irector		5. Sociel Security 212-18-		6. Sex	M 2 🗆 F	Age (In yrs.	. lest birthday Yrs.	) if Under Months	1 Year Deys	if Under Houra	24 Hrs. Min.	8. Dete of Bi (Month, Di DEC 29	th ey, Year) 1915	9. Birth Con MAR	piace (S intry) LANI	fate or Foreign
28a-f show notified at		Usuel Residence 10a. Stete MD	10b. Coun	ty RETT		10c. C	ity, Town or t									de City Limits Yes 2 No
23a or 28a ust be not	Funeral Director	10e. Street and No.	umber OODLAN	D DRI	IVE			10f. Zip	Code 1550				10g. Citizen USA	of What Cou	intry?	
2.5	P P	11. Maritel Stetus 1 Never Mai 3 Widowed	rried 2 Ma	arried	2. Wes Deced Armed Ford 1 Tes 2 if Yes, Give Year or Det	es? XINo	J,S. 13.	Was Deced if Yes, spec 1 Yes		spenic Ori n, Mexican Specify:	gin? (Sp i, Puerto	ecity Yes or No Rican, etc.)		Rece - Amar Black, White city: WH		an,
natur	Completed	(Specification)	15. Decede ecify only high condery (0-12)	nest grade	cation completed) Coilege (1-4	lor 5+)	(Giv life.	edent's Usua e kind of wo DO NOT us DME BU	rk done d se retired	dunin <i>g m</i> osi )	t of work	ing		Business/i		N
marked other than	To Be C	17. Fether's Neme		e, Last) HARD	LEIG	HTON				18. Mothe		e (First, Middle ANN	SINES	neme)		
om 27 is me ther traums		19e. informent's P					19b. Mei 31			ond Numbe		al Route Numb	AND, M			
Important: If item 27 any injury or other to phose.		20e. Method of Di 1 X Burial 2 4 Donetion	2 Cremation		emovei from St	ato	Plece of Disp cemetery, cri RRETT	emetory or o	other plea		NG 1	Dete 2 / 2 7 / 9	20c. Location	AND,		
Important: It any injury o		21. Signature of								OMICDL	NO 11	2/2//	OILL	,		
FEE		skol	w)	ce License	uet	M0016	2	22. Name ar	nd Addres	s of Facilit	y		BOX 2	43	50	
vsician legical aminer	her	23a. Pert1. Enter shock, or he immediate Ceuse disease or conditions and the ceuting in deeth	the disease, part failure. Li	1De	cations that cere e cause on each	used the dee ch line.	57 I	OURST Inter the mod	FUNE	RAL H	HOME cardiec	P.O. - OAKL	BOX 2 AND, M	43	Appro intervi Onset	ximete al Between and Deeth
hysician and property in the bundi-fransit	dical Examiner	23a. Pert1. Enter shock, or he	r the disease, part failure. Li	1De	cations that cere e cause on each	LIOSCLI Due to (	57 I oth. Do not ea	CORON equence of):	FUNE de of dyln NARY	RAL H	HOME cardiec	P.O. - OAKL	BOX 2 AND, M	43	Appro intervi Onset	el Between and Deeth
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31. Dete filed (Month, Dey, Year)

P. DANIEL MILLER, D.O.

29b. Signety Pand title of certifier

DEC 2 8 1998

30. Neme end eddress of person who completed cause of deeth (item 23a) (Type, Print)

OAKLAND, MD 21550

29d. Dete signed (Month, Dey, Year)

Registrar

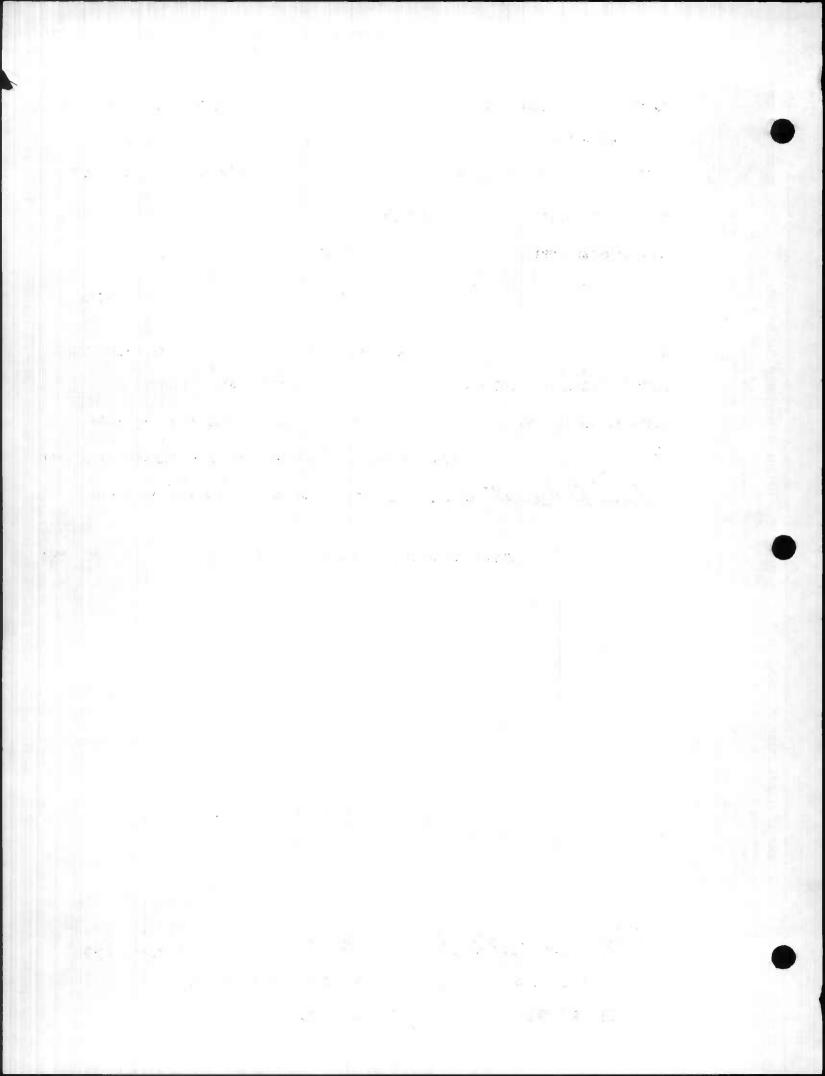
32. Registrer's Signeture



69 WOLF ACRES DRIVE

29c. License number

H26154



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 4 500

		Certificate of Death Reg. No.											
		Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year					Death
Physician /Medical		William Edwin Love							December		1998	1800	)
	miner	4a Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death				of Deeth		
Funeral		PENINSULA REGIONAL MEDICAL CENTER SALISI						LISB	URY	WI	COMIC	0	
	ral	Social Security Number     6. S.	rthday) If Unde	1 Year Devs	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Birth 9. B		Birthplace (State or Foreign Country)			
Direct	or								June 3,				
5-0020 72 hours after death with the Maryland natural; or items 23a or 28a-f show or at Examiner must be notified at		10s. State 10b. County 10c. City, Town or Location									1	0d. Inside City	Limits
	tor	Maryland Caroline Denton										1 Tyes 2	No X
	Director	10e. Street and Number 10f. Zip Code							1	10g. Citizen of What Country?			
	ai	7295 Dion Road 21629								United	State	25	
	Funeral	11. Meritel Status		. Wes Decedent Ever in U.S. 13. Armed Forces?		dent of I	Ispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	14. Race - American Indian, Bleck, White, etc.		
	F	1 ☐ Never Merried 2 € Merried	1 ☐ Yes 2 ☐	No	1 ☐ Yes 2 🕱 No				1 110411, 010.7	Specif	C. Parito	010.	
ours ours	d by	3 Widowed 4 Divorced	Year or Dates:						Caucasian		an		
21215-002 d within 72 hours jiene. r than "natural",	Completed	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business/Industry			
	idu idu	Elementary/Secondary (0-12) College (1-4or 5+)				NOT use retired)							
o filed wall Hygies other the		12 HS Grad.		Farmer			10 Mathada Nama /First Mid			Farming			
itimore, Maryla  1. Pages 1 and 2 should b frment of Health and Ment framt: if Ham 27 is marked jury or other traumatice	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Sumame)						
	2	Frederick Earl				10.			ce Eli				
		19a. Informent's Name/Relationship (1	Type, Print)	198	. Mailing Addres	s (Street	t end Numb	er or Run	al Route Number	r, City or Town	, Stete, Zip	Code)	
		Betty L. Love	Wife		295 Dion of Disposition (Na		ad, De	enton			1629	um Ctate	
		20e. Method of Disposition  1 Burial 2 Cremation 3	Removal from Stete	camete	ry, crematory or	other pla	ice)	1	Date	20c. Location	- City or To	wn, State	
		4 □ Donation 5 □ Other (Specify	")	Conco	rd Cemet	ery		1	/2/99	near De	enton	, Maryl	and
	DUC.	21. Signature of Funeral Service Licen	see )		22. Name a				D 3				
405	Ci .	Moore Funeral Home, P.  12 South Second Street  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause on each line.									Mary	land 21	620
in a in a	er	Immediate Cause (Final disease or condition resulting In death)  Due to (or as e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):											
	n/Medical Examiner												
death deather e atter	Cia	Dod to Character Management and Management and Assessment and Asse						23b. Did tobacco use contribute to the cause of death					
ds, F.C. DOX ires that the death cert signed by the attendin d be detached for use	Phys	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						1 Yes 2 No 3 Probably 4 Unknow					
ne law requires the has been signed ge 2 should be d	Completed by Physician		100	C0					24e. Was an autopsy 24b. Were autopsy findings				
law require as been si	et	Me te ventre prostate concer							performed? available prior to completion of caus of death?			.use	
The la ate has page 2	E		(						элгу	69 2 No	- 11	Yes 201	Vo.
sicien: The law cartificate has b lirector, page 2 s		25. Was case referred to medical				-	28 Plac	e of Deat	h (Check only or			3103 201	
DIVISION OF  or Attending Phy after death.  Director: After this in by the funeral of	To Be	evaminer?	Hospital:	nt 2   EB/0	utpatient 3 D	Ot Ot	hor		me 5 Resid		her (Snecil	(v)	
		27. Mann Deeth 28e. Dete of Injury 28b. Time of 28c. Injury at 1 leturel 5 Pending (Month, Day Year) Injury Work?								d. Describe how Injury occurred			
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Inju							8f, Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital within 24 hours To the Funeral completely filled	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the Within 2 To the	× ×	29b. Signa ure and title proertifier 29c. License number							2	29d. Date signed (Month, Day, Year)			
7 × 7 00		D256711							12/70/22				
										87)017			
		30. Nome and address of person who completed cause of death (Item 23e) (Type, Print)  TAI ( octror Mo (00 Power, 54, Latisbury, Md. 2,804)											
	State	31. Date filed (Month, Dey, Year)	1 1	ar's Signature	4 1	200	Val.		7	1			
	istrar	JAN - 5 19	199		1. 14								

Registrar

30-1811

